

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician, and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2637 CERTIFICATE OF DEATH

Reg. Dist. No. **12584**

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		b. COUNTY AA	
c. LENGTH OF STAY IN 1b 24 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 419 Crain Highway SE		d. STREET ADDRESS 419 Crain Highway SE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle H.	Last Adams, Sr
4. DATE OF DEATH	Month 3	Day 4	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22, 1874
9. AGE (In years lost birthday) 85	10. IF UNDER 1 YEAR Months 85	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Printer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Robert Adams	14. MOTHER'S MAIDEN NAME Julia Longworth	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 215-10-8737	17. INFORMANT Mrs Mary Ellen Adams, same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-Vascular Disease INTERVAL BETWEEN ONSET AND DEATH 3 yrs.			
443X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)			
DUE TO			
C (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1958 , to March 1959 , that I last saw the deceased alive on March 3 1959 , and that death occurred at 6A , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) C. R. MacDonald, M.D. DATE SIGNED 3-5-59			
ACTUAL SIGNATURE C. R. MacDonald, M.D.		M.D.	
PHYSICIAN'S NAME (Type)		204 Crain Highway SW, Glen Burnie	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/7/59	22c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn
22d. LOCATION (City, town, or county) Baltimore, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley, Glen Burnie, Md.		24a. REC'D BY REGISTRAR ADDRESS Skirkley	24b. REGISTRAR'S SIGNATURE Arthur S. Krause
		DATE MAR 6 '59	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2594

CERTIFICATE OF DEATH

02585

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL Hospt.</u>		d. STREET ADDRESS <u>1108 West St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>GEORGE</u>	Middle <u>W.</u>	Last <u>Aouiotis</u>
4. DATE OF DEATH	Month <u>3</u>	Day <u>27</u>	Year <u>1959</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26 1916</u>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <u>42 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Amusement Co Coin Machine</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
10c. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Aouiotis</u>		14. MOTHER'S MAIDEN NAME <u>Maria Kasapis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>BETTRICE Aouiotis</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute myocardial infarction</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <u>Coronary artery disease</u> (c) <u></u> <u>6 mos.</u>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February</u> , 1959, to <u>March</u> , 1959, that I last saw the deceased alive on <u>March 24, 1959</u> , and that death occurred at <u>721 Cathedral</u> , M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 Cathedral</u> DATE SIGNED <u>3/25/59</u>			
ACTUAL SIGNATURE <u>John L. H. DeMaree</u>		M.D. <u>121 Cathedral</u>	
PHYSICIAN'S NAME (Type)		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-27-59</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>ST. JAMES</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Poyntons Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>	

11-20000-1114000 (MICHIGAN STATE POLICE)

MAILED TO STATIONED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2595

CERTIFICATE OF DEATH

82586

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 4 Yrs. Approx		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis		d. STREET ADDRESS Seven Oaks, Wardour		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Seven Oaks, Wardour, Anna. Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Laurie		First	Middle	Last	4. DATE OF DEATH MAR	Month	Day	Year
5. SEX F		6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 31 Jan 1892	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-Realtor		10b. KIND OF BUSINESS OR INDUSTRY Housewife-Realtor		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Edward SMITH			14. MOTHER'S MAIDEN NAME Frances CAIRNS					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —			16. SOCIAL SECURITY NO. 076-12-6433			17. INFORMANT CAPTAIN Edward Baldridge		
						Address 214 Wolfe Street Alexandria, Virginia		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) Hypertension cardiovascular disease DUE TO (c)			Cerebral hemorrhage			INTERVAL BETWEEN ONSET AND DEATH None		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1957, 19, to March, 1959, that I last saw the deceased alive on March 10, 1959, and that death occurred at M, from the causes and on the date stated above. ACTUAL SIGNATURE John L. HEDEMAN M.D.						ADDRESS (Street, city or town, state) DATE SIGNED 3/27/59		
PHYSICIAN'S NAME (Type) John L. HEDEMAN			121 Cathedral Street, Annapolis, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal-burial march 27, 59			22b. DATE THEREOF REMOVAL (Specify) March 27, 59			22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery		
						22d. LOCATION (City, town, or county) Woodlawn, New York (State)		
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME			ADDRESS Annapolis, Maryland			24a. REC'D BY REGISTRAR DATE MAR 30 '59		
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

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WISCONSIN STATE HIGHWAY
DEPARTMENT - DIVISION OF HIGHWAYS

STATE OF WISCONSIN

For To

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02587

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Gambrills			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AA General Hospital				d. STREET ADDRESS Naval Academy Dairy Farm		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Jauniata	Middle Mamie	Last Anderson	4. DATE OF DEATH March 1, 1959	Month March	Day 1	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 8, 1939	9. AGE (In years last birthday yrs.) 20	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wallace Roberts				14. MOTHER'S MAIDEN NAME Ellie Vaughn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Charles Anderson, same as 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage INTERVAL BETWEEN DUE TO 754.7 ONSET AND DEATH 24 Hrs. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Congenital Aneurism							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Pregnancy 4 1/2 mo 6 wks 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT/WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Gambrells, Md.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 19, 1959 , to Mar 1, 1959 , that I last saw the deceased alive on Mar 1, 1959 , and that death occurred at 6:05 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Edward G. Skerritt ADDRESS (Street, city or town, state) Gambrells, Md. DATE SIGNED 3-3-59							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/59		22c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Memorial		22d. LOCATION (City, town, or county) Glen Burnie, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley		ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR MAR 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Tracy	

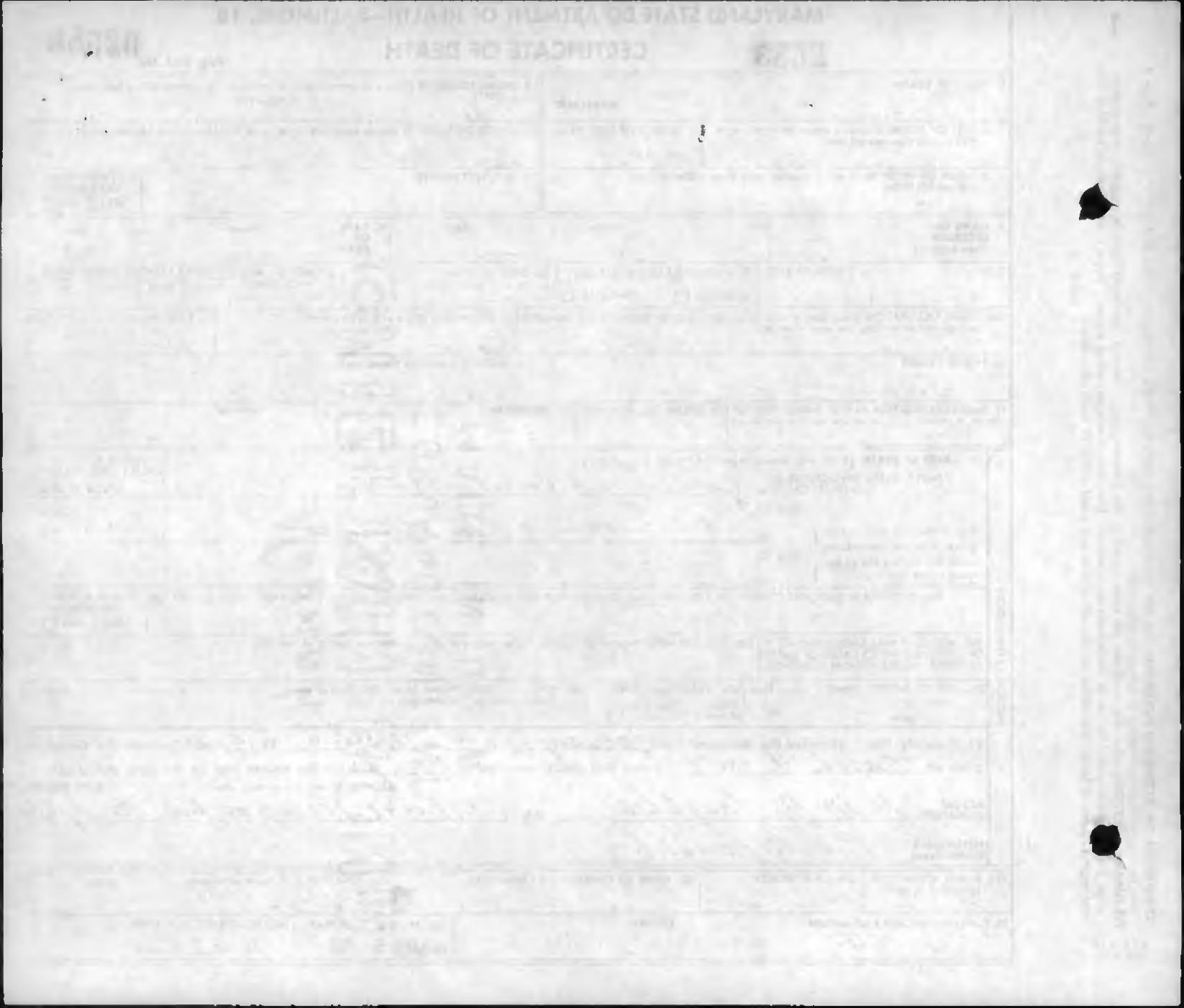
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
2638 CERTIFICATE OF DEATH 02588
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena RFD</i>		c. LENGTH OF STAY IN 1b <i>4 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Long Point (Pasadena RFD)</i>		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Long Point</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>John</i>		First <i>John</i>	Middle <i>S.</i>	Last <i>Angel</i>	4. DATE OF DEATH <i>March 4, 1959</i>	Month <i>March</i>	Day <i>4</i>	Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 3, 1907</i>	9. AGE (In years last birthday) <i>51</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. IF UNDER 24 HRS. Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chaffer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self Emp.</i>		11. BIRTHPLACE (State or foreign country) <i>W. Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>James Z. Angel</i>		14. MOTHER'S MAIDEN NAME <i>Mae (Unknown)</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>			
17. INFORMANT <i>Mrs. Rachael Angel</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>generalized carcinoma</i>		19. ADDRESS <i>Same as #7</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>carcinoma of the lungs</i>		DUE TO (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>March 4, 1959</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Long Point</i>		20f. (City or town) <i>Baltimore</i>		(County) <i>Baltimore</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>January 3, 1959</i> to <i>March 4, 1959</i> , that I last saw the deceased alive on <i>March 4, 1959</i> , and that death occurred at <i>2:10 A.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>M.D. RFD 8 Box 442 Pasadena, Md. Mar. 4, 1959</i>		DATE SIGNED			
ACTUAL SIGNATURE <i>R. M. McLaughlin</i>									
PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>March 7, 1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>London Park</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. J. Senington</i>		ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR <i>MAR 5 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Orlilia S. Krause</i>			

STATE OF HAWAII
DEPARTMENT OF STATE
CERTIFICATE OF DEATH



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7, File 6241, 4/10/59 rec

102589

Reg. Dist. No

1. PLACE OF DEATH a. COUNT 2639 Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN lb

2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission)

a. STATE Maryland b. COUNTY A.A.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis

3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

St. 4 Bay 28A. Annapolis

4. NAME OF DECEASED (Type or print) First Estella Middle Baldwin

5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH

Female Col. WIDOWED DIVORCED 12-26-1893

10a. OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country)

Domestic Nutglaskinly A.A. Co. Md.

13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME

Job Stansbury Delta Stansbury

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT

770 212-32-058 Evelyn Addison St. 4 Bay 28A. Annapolis

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

434.4 DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. (b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year

Hour a.m. 19 p.m.

20d. INJURY OCCURRED While Not while

at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined manner

Actual Signature

E. L. Whiskett.

Date Signed

EXAMINER'S NAME (Type)

MD CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

3/30/59

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial 4-3-59

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS

Broad Neck

22d. LOCATION (City, town, or county)

St. Margaret's, Md.

State

23. FUNERAL DIRECTOR'S SIGNATURE

William Geese, Jr. Annapolis, Md.

ADDRESS

24a. REC'D BY REGISTRAR

DATE MAR 31 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Thomas

1 A15ME
8M 2.57



1
FOR STATE
HEALTH DEPT.
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. File pages 1 and 2 with the State Board of Health.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02500

Reg. Dist. No.

2640

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived if institution residence before admission) a. STATE Maryland b. COUNTY Worcester Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup, Md.		c. LENGTH OF STAY IN lb 18 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Md. House of Correction Hospital		e. STREET ADDRESS Cambridge	
f. S P E C I A L ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		92	
3. NAME OF DECEASED (Type or print) M James		First Middle Bell	4. DATE OF DEATH Month March Day 7 Year 19 59
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-6-10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Bell		14. MOTHER'S MAIDEN NAME Belle Carry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Gangrene of Small Bowel</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adhesive Band</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? partial <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 6. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) partia
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles S. Petty</i>		DATE SIGNED	
EXAMINER'S NAME (Type) Charles S. Petty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, DATE THEREOF REMOVAL (Specify) Burial 3-13-59		22c. NAME OF CEMETERY OR CREMATORIAL Silent City	
22d. LOCATION (City, town, or county) Cambridge, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE LEON HENRY, 222 Cedar St., Cambridge, Md.		24a. REC'D BY REGISTRAR DATE APR 1 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1
VS AISC 155 10A

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2641 CERTIFICATE OF DEATH

02591

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Maryland Anne Arundel (If rural give location)		
Anne Arundel Lakeshore	4 yrs.	Lakeshore	5 Luke Drive		
HOSPITAL OR INSTITUTION OR STREET ADDRESS	5 Luke Drive				
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)		
Keith Eugene Bennett					
4. DATE OF DEATH	(Month)	(Day)	(Year)		
March 2, 1959					
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months Days Hours Min.
Male	White	MARRIED	July 25 1919	39 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?
Projectionist	Motion Pictures	Maryland			U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME				
MAX BENNETT	Mary Thompson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.			17. INFORMANT & ADDRESS	
YES World War II	7			JEAN BENNETT 5 Luke Drive	
18. MEDICAL CERTIFICATION					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
19. IMMEDIATE CAUSE (A) CIRCULATORY FAILURE 12 HOURS					
ANTECEDENT CAUSE(S) DUE TO					
DISEASES OR CONDITIONS, IF ANY, (B) WEIGHT LOSS, WIDE SPREAD METASTASES 1/4 year					
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO					
(C) CARCINOMA OF TESTIS					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OR INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. <input type="checkbox"/> White <input type="checkbox"/> Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from on 3-2, 1959, to 3-2, 1959, that I last saw the deceased alive on 3-2, 1959, and that death occurred at 6:10 P.M. from the causes and on the date stated above.					
SIGNATURE <i>W. Vogel Jr. D</i> ADDRESS (Street, city, town, state) <i>AD 03 RITCHIE H. GLEN BURNIE</i> DATE SIGNED <i>3-3-59</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>By rail</i>		DATE THEREOF <i>3/5/59</i>	NAME OF CEMETERY OR CREMATORIUM <i>Baltimore National</i>		LOCATION (City, town, or county) <i>Baltimore, Md.</i>
24. REC'D BY REGISTRAR <i>By rail</i>		REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>650 E. Schubert Funeral Home</i>		
DATE MAR 6 '59			Barber M. Schubert 2101 Frederick Ave		



1
FOR STATE
HEALTH DEPT.
I
A should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02592

Reg. Dist. No.

2642

1. PLACE OF DEATH a. COUNTY Anne Arundel	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Severna Park	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Severna Park	
3. NAME OF DECEASED (Type or print) First VELETA	Middle T.	4. DATE OF DEATH Month March Day 18 Year 1959
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 11-16-1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years from birthday) yrs
13. FATHER'S NAME Elbert E. Best	14. MOTHER'S MAIDEN NAME Lillie M. Jackson	15. IF UNDER 1 YEAR Months 4 Days 10 Min
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT Lillie M. Jackson, Severna Park
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia due to otitis media, bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.	CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED March 18, 1959
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial 3-20-59	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Carpenter Hill	22d. LOCATION (City, town, or county) Rehoboth Bay, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Whitecross #103 West Atlantic Blvd	24a. REC'D BY REGISTRAR MAR 23 '59	24b. REGISTRAR'S SIGNATURE Russell S. Fisher



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2597

CERTIFICATE OF DEATH

02593

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. A.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md.</i>		c. LENGTH OF STAY IN MD <i>24 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel Gen Hosp</i>		e. STREET ADDRESS <i>Arnold</i>	
3. NAME OF DECEASED (Type or print) <i>Charles</i>		First <i>C</i>	Middle <i>l</i>
4. DATE OF DEATH <i>3 2 1959</i>		5. DATE OF BIRTH <i>July 31, 1913</i>	6. AGE (In years last birthday) <i>45</i>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. IF UNDER 1 YEAR Months <i>0</i>	
9. IF UNDER 24 HRS Days <i>0</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>54-01-1263</i>	
17. INFORMANT <i>Self</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>	
DUE TO <i>400.1</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last <i>Coronary failure</i>			
DUE TO <i>(b)</i>			
DUE TO <i>(c)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1957</i> to <i>1959</i> , that I last saw the deceased alive on <i>3-1-59</i> , and that death occurred at <i>334 M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Robert Ritter, M.D. 334 M. Arnold, Md.</i>			
DATE SIGNED <i>3-2-59</i>			
ACTUAL SIGNATURE <i>Robert Ritter, M.D.</i>			
PHYSICIAN'S NAME (Type) <i>Robert Ritter</i>			
22a. BURIAL CREMATION, REMAINS (Specify) <i>Burial</i>		22b. DATE THEREOF <i>March 1959</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Arbory Hill Crematory</i>		22d. LOCATION (City, town, or county) <i>Arnold, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard G. Frick, Helen Burns, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>Mar 11 1959</i>	
24b. REGISTRAR'S SIGNATURE <i>Robert Ritter</i>			



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

82595

2643

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		d. STREET ADDRESS Tick Neck Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Edward	Middle S.	Last Bradley.	4. DATE OF DEATH March 18, 1959	Month March	Day 18	Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	April 10, 1874	9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. HOURS Hours 0	13. MIN.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Lumber Mill		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown.							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 2113-34-4288		17. INFORMANT		Address Clifton Bradley. Tick Neck Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Cerebro-vascular accident						2 days	
DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Generalized arteriosclerosis						Several years	
DUE TO									
(b)									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION MENTIONED IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) acute myocardial infarction							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Clifton		(County) Baltimore	(State) Md.
21. I certify that I attended the deceased from May 1, 1956 to March 18, 1959 , that I last saw the deceased alive on March 17, 1959 , and that death occurred at 1145 A.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state) Clifton Bradley, Md.	
ACTUAL SIGNATURE R. M. McLaughlin		DATE SIGNED March 18, 1959							
PHYSICIAN'S NAME (Type) R. M. McLaughlin									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/21/59		22c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn		22d. LOCATION (City, town, or county) Eastern Ave., Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Austin C. Donovan		ADDRESS 3818 Roland Ave.		24a. REC'D BY REGISTRAR MAR 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



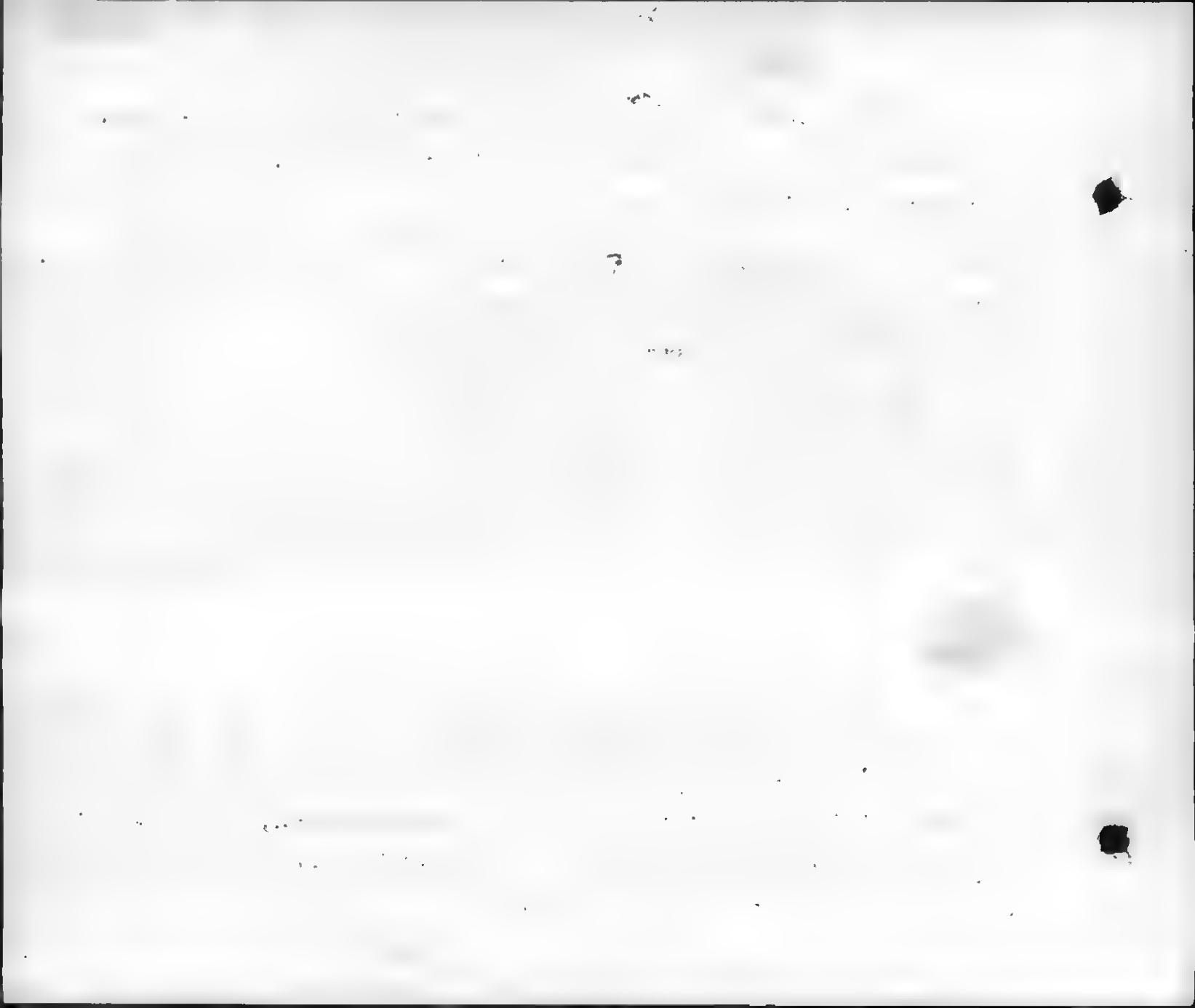
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be required by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18 Film 545 4-6-59 ams MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 6, 7, 11, 12, 13, 14 File G239 3-9-59 et 02598

CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Annapolis, Md.	
c. LENGTH OF STAY IN 1b 1 day		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED [Type or print] George		First George	Middle
4. DATE OF DEATH March 1 1959.		Last BROOKS	Month March
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1-2-05		9. AGE (In years lost birthday) 54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker		10b. KIND OF BUSINESS OR INDUSTRY Beach	
11. BIRTHPLACE (State or foreign country) ?		12. CITIZEN OF WHAT COUNTRY? ?	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 49		16. SOCIAL SECURITY NO INFORMANT Address	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO 49 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1, 1959 to March 1, 1959 , that I last saw the deceased alive on March 1, 1959 , and that death occurred at 2:25 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Aris T. Allen</i>		ADDRESS (Street, city or town, state) 62 Cathedral St., Annapolis, Md. DATE SIGNED 3/3/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3-3-59	
22c. NAME OF CEMETERY OR CREMATORIUM Annapolis to 217 Md.		22d. LOCATION (City, town, or county) Baltimore (State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Keasey		24a. REC'D BY REGISTRAR DATE Mar 5 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Ervin S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02596

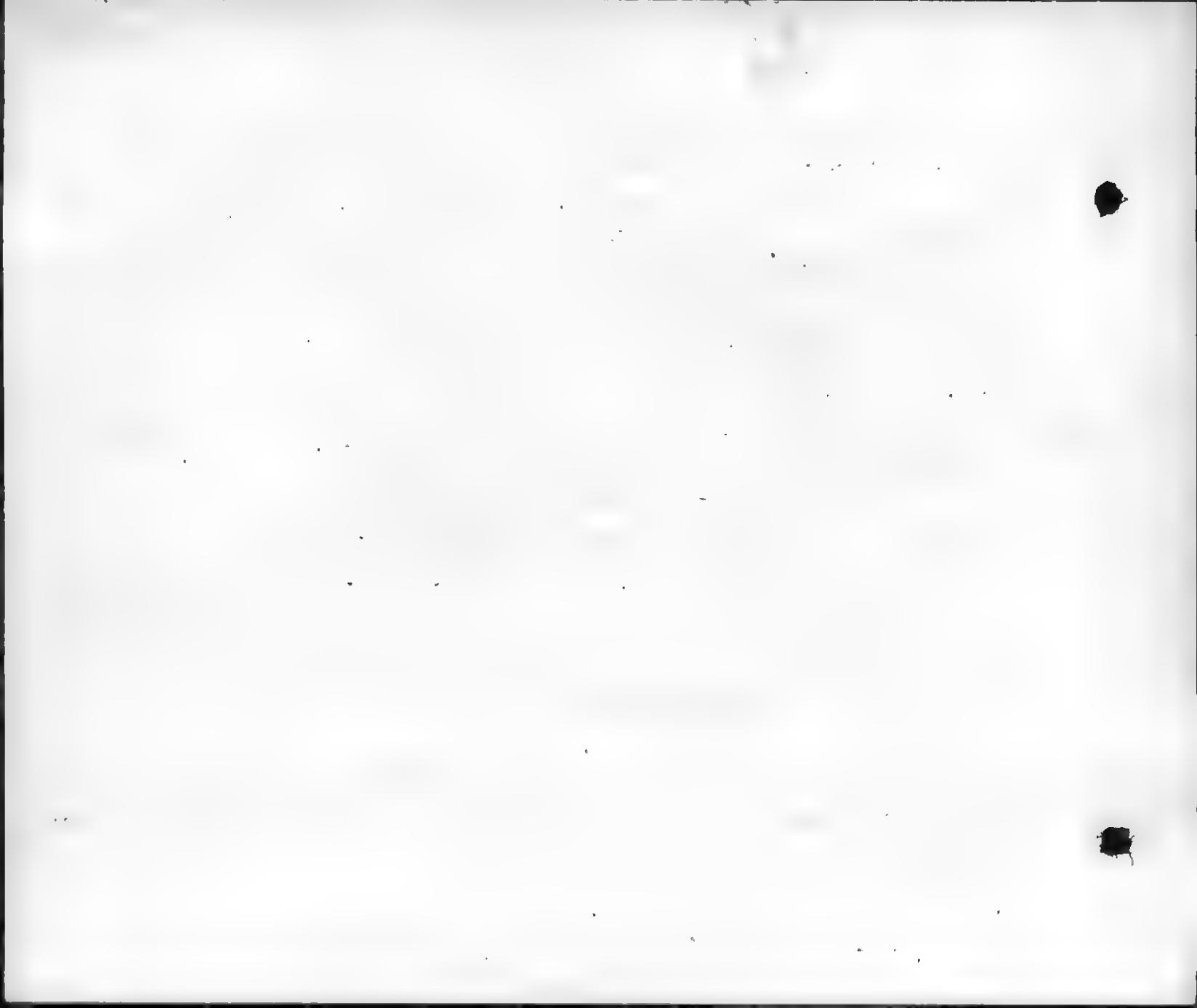
2599

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ANNAPOLIS</i>		c. LENGTH OF STAY IN 1b <i>1 DAY</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>ANNE Arundel Gen. Hospital</i>		e. STREET ADDRESS <i>42 Lafayette Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Benjamin Brown</i>		First <i>B</i>	Middle <i>E</i>
4. DATE OF DEATH <i>MAY 20 1959</i>		Month <i>MAY</i>	Day <i>20</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>MAY 9-1888</i>		9. AGE (In years (at birthday) yrs. <i>70</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DAIRY Co. Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Anne Arundel Co. Md.</i>	11. BIRTHPLACE (State or foreign country) <i>Anne Arundel Co. Md.</i>
12. CITIZEN OF WHAT COUNTRY <i>Anne Arundel Co. Md.</i>		13. FATHER'S NAME <i>Daniel Brown</i>	
14. MOTHER'S MAIDEN NAME <i>Mariel Little</i>		15. WAS DECEASED EVER IN J. S. ARMED FORCES? 16. SOCIAL SECURITY NO <i>218-12 918-A</i>	
17. INFORMANT <i>ANNIE B. Johns - 42 Lafayette Ave</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>33IX</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Cerebral Hemorrhage</i> <i>arterio sclerotic hypertension</i> (c) <i>Cerebral disease</i>	
19. INTERVAL BETWEEN ONSET AND DEATH		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on <i>March 20, 1959</i> , and that death occurred at <i>10 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Dr. Bill Brown</i>		ADDRESS (Street, city or town, state) <i>110 E. 87th St. Baltimore, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>3-24-59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Brewer-Hill</i>
22d. LOCATION (City, town, or county) <i>ANNAPOLIS Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>CHARLES F. HICKS III ANNAPOLIS Md.</i>		24a. REC'D. BY REGISTRAR DATE <i>MAR 26 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02597

2644

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ventor Md.		c. LENGTH OF STAY IN 1b 6 Mths.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ventor Md.		d. STREET ADDRESS Ventor Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ventor Road						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First CHARLES	Middle HAMILTON	Last Brown	4. DATE OF DEATH MARCH 31 1959	Month Month Days Hours Min	Day Year
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-23-1883	9. AGE (In years lost birthday) 75 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Woodensburg, Balto, Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel H. Brown		14. MOTHER'S MAIDEN NAME Mart Melching					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input checked="" type="checkbox"/> For or unknown		16. SOCIAL SECURITY NO 417-03-3745		17. INFORMANT Alice May Brown		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH 2 HOURS	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 445X		CEREBRAL HEMORRHAGE					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE				5 YEARS	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 18, 1958</u> to <u>MARCH 31, 1959</u> , that I last saw the deceased alive on <u>MARCH 30, 1959</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Pasadena, Md.	
ACTUAL SIGNATURE J. Brady Smith		M.D.				DATE SIGNED 3/31/59	
PHYSICIAN'S NAME (Type) J. BRADY SMITH							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-2-59		22c. NAME OF CEMETERY OR CREMATORIAL Meadowridge		22d. LOCATION (City, town, or county) Washington Rd. Dorsey Md. (State)	
23. FUNERAL-DIRECTOR'S SIGNATURE Frank R. Moore		ADDRESS Gibsonville 8, Md.		24a. REC'D BY REGISTRAR DATE APR 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 1 Pg. 2, Sec. 10 3-30-59 et
2645 CERTIFICATE OF DEATH

02599

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>N. J.</i>		b. COUNTY <i>Bergen</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewater</i>		c. LENGTH OF STAY IN 1b <i>5 months</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Upper Saddle River</i>		d. STREET ADDRESS <i>44 Lake Rd.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Daughter's home</i>				d. STREET ADDRESS <i>44 Lake Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>William</i>		First	Middle	Last	4. DATE OF DEATH <i>Butscher</i>	Month <i>3</i>	Day <i>20</i>	Year <i>1959</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 6, 1872</i>	9. AGE (In years last birthday) <i>86 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 MRS. Days <i>0</i>	Hours <i>0</i>	Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>New York City</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Otto Butscher</i>		14. MOTHER'S MAIDEN NAME <i>Louise Gumpert</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Sherwood H. Butscher (son)</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>443 X</i>		DUE TO <i>cardiac failure</i>				INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first (b) DUE TO <i>Hypertensive cardiovascular disease</i>						3 months			
(c) DUE TO <i>and carcinoma of prostate</i>						2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>RFD #1 Box 277-14</i>		(County) <i>Edgewater, Maryland</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Jan 3, 1959</i> to <i>March 1959</i> , that I last saw the deceased alive on <i>March 20, 1959</i> , and that death occurred at <i>6:40 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Edgewater, Maryland</i> DATE SIGNED <i>3-20-59</i>									
ACTUAL SIGNATURE <i>Sylvia M. Lim</i>		M.D.							
PHYSICIAN'S NAME (Type) <i>Sylvia M. Lim, M.D.</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>3-23-59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>77 Lincoln Cemt</i>		22d. LOCATION (City, town or county) <i>Prince George Co</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jean M. Taylor Sons Cremapolis Md</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>Mar 24 '59</i>		24b. REGISTRAR'S SIGNATURE <i>John S. House</i>			



INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL - This law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completed, file it in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A1SC 1-10

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

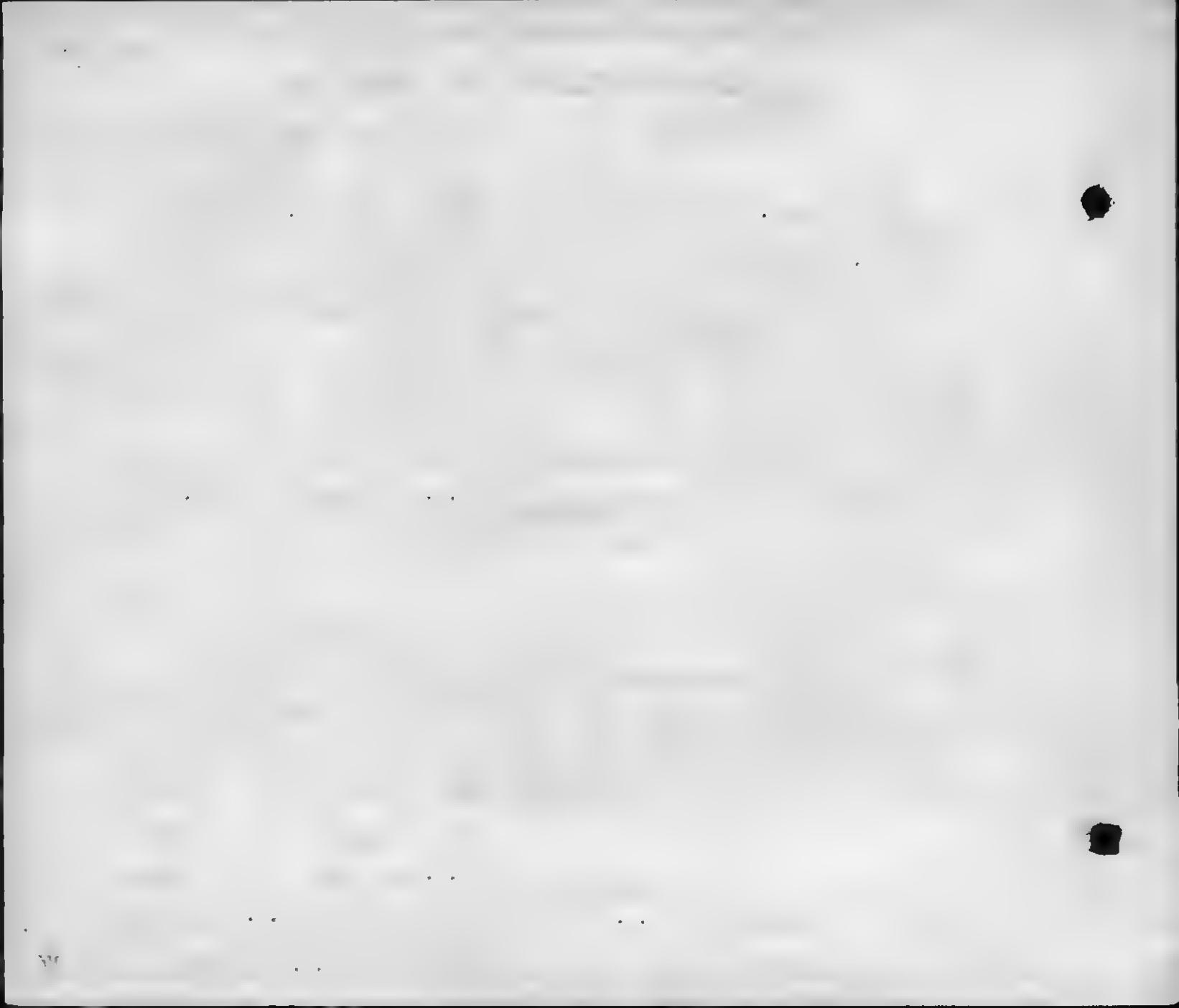
02600

CERTIFICATE OF DEATH

2646 Item 5, see birth Cert. et

Reg. Dist. No. 27

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Anne Arundel Fort George G. Meade	MARYLAND LENGTH OF STAY (In this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ft George G. Meade
HOSPITAL OR INSTITUTION OR STREET ADDRESS	U.S. Army Hospital		
3. NAME OF (First) Frank (Type or Print)		(Middle) Gerard	(Last) Carr, Twin II
4. DATE OF DEATH	(Month) March	(Day) 7	(Year) 1959
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED X MARRIED WORKER (Spouse)	8. DATE OF BIRTH
Male	Cau		5 March 1959
9. AGE last birthday yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country)
2	Infant	-	Maryland
13. FATHER'S NAME	14. MOTHER'S M AIDEN NAME		
John Perry Carr	Marie Tieyah		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS	
No	-	Hospital Records U.S. Army Hosp, Ft Meade, Md	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
77% IMMEDIATE CAUSE (A) Prematurity			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE			
STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town)	(County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5 March 1959, to 7 March 1959, that I last saw the deceased alive on 7 March 1959, and that death occurred at 1145 A.M. from the causes and on the date stated above. SIGNATURE			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		DATE THEREOF 9 March 59	NAME OF CEMETERY OR CREMATORIAL Laboratory U.S. Army Hospital
24. REC'D BY REGISTRAR DATE MAR 12 '59		REGISTRAR'S SIGNATURE Arthur & Anna	LOCATION (City, town, or county) Ft G. Meade, Md
25. FUNERAL DIRECTOR'S SIGNATURE Signature		ADDRESS U.S. Army Hosp, Ft Meade, Md	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 5, a 60 in Cert. et
2647

CERTIFICATE OF DEATH

02601

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade, Md		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade,							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital		/ d. STREET ADDRESS Bldg 2365 Apt A		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Norma		Middle Jean		4. DATE OF DEATH Twin I Carr		Month March	Day 6	Year 1959			
5. SEX Female		6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 March 1959		9. AGE (In years last birthday) yrs. Months Days	10. IF UNDER 1 YEAR Hours 27	11. IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John Perry Carr		14. MOTHER'S MAIDEN NAME Marie Tieyah		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Father Bldg 2365 Apt A, Ft George G. Meade, Md			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.5		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Tung disease—possible hyaline membrane disease		INTERVAL BETWEEN ONSET AND DEATH 21 hours			
DUE TO Pre-existing				(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 5 March 1959, to 6 March 1959, that I last saw the deceased alive on 6 March 1959, and that death occurred at 8:10 AM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE FRED W. TIEYAH						FRED. US ARMY H. SP. FT GEORGE MEADE, MD 6 MARCH 59					
PHYSICIAN'S NAME (Type)		FRED W. TIEYAH, Capt., MC									
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6 March 59		22c. NAME OF CEMETERY OR CREMATORIAL U.S. Army Hosp (Laboratory)		22d. LOCATION (City, town, or county) Ft George G. Meade, Md		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Krause		ADDRESS FORT GEORGE MEADE, MD		24a. REC'D BY REGISTRAR MAR 12 1959 DATE		24b. REGISTRAR'S SIGNATURE Arthur L. Krause					
VS A15 (2) ISM 9/55											

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02602

2648

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Maryland City</i>		c. LENGTH OF STAY IN 1b <i>1 month</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SANN'S NURSING HOME</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>ELLA</i>	Middle <i>M.</i>	Last <i>CASTLES</i>				
4. DATE OF DEATH	Month <i>3</i>	Day <i>10</i>	Year <i>1959</i>				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-20-1875</i>				
9. AGE (In years last birthday) <i>83 yrs</i>	10. IF UNDER 1 YEAR Months <i>83</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>George Bissell</i>	14. MOTHER'S MAIDEN NAME <i>W. A. T. e., Amanda</i>	Address <i>711 Newburger, Baltimore, Md.</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>None</i>	INFORMANT <i>Mary Newburger</i>	17. INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>490X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUT NOT TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION LISTED IN PART I(a) <i>Cerebral Hemorrhage</i> <i>Lobar Pneumonia</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i>No</i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Cerebral Hemorrhage - 6 months</i>	20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i>None</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	20f. (City or town) <i>None</i>	(County) <i>None</i>	(State) <i>None</i>
21. I certify that I attended the deceased from <i>3-9-59</i> to <i>3-27-59</i> , that I last saw the deceased alive on <i>3-9-59</i> , and that death occurred on <i>3-27-59</i> M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>DR. JOSEPH LIPSKY</i> PHYSICIAN'S NAME (Type) <i>Montgomery, Maryland</i>	ADDRESS (Street, city or town, state) <i>Montgomery, Md.</i> DATE SIGNED <i>3-27-59</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-13-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>West Laurel Hill Cemt</i>	22d. LOCALITY (City, town, or county) <i>Philadelphia, Pa.</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Son</i>	ADDRESS <i>Annapolis Md</i>	24a. REC'D BY REGISTRAR DATE <i>MAR 12 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

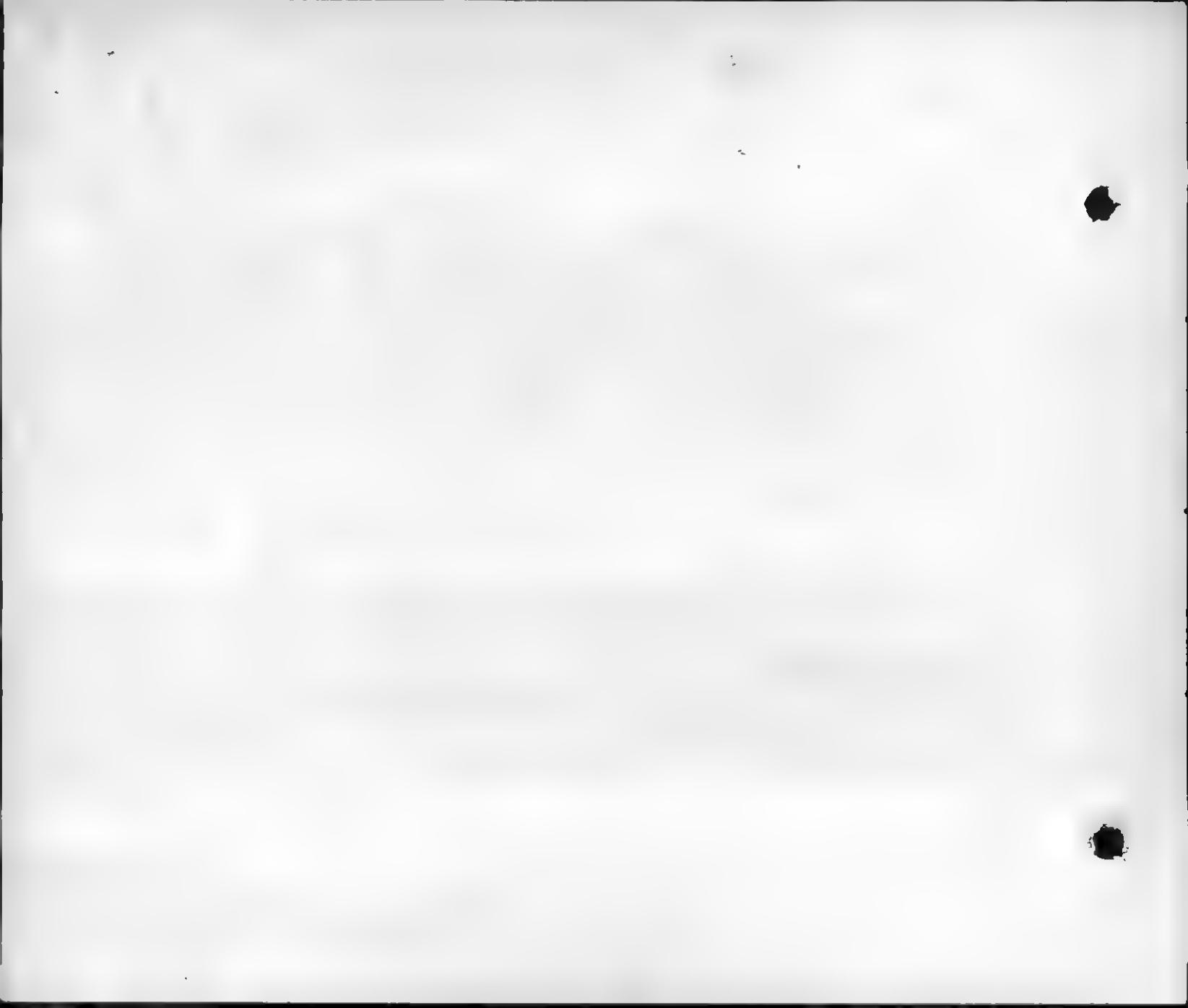
02603

CERTIFICATE OF DEATH

Reg. Dist. No.

2649

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
Anne Arundel MARYLAND		a. STATE	b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1B	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
DILL RD	9 yrs	Severna Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS			
Severna Park		1 DILL RD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First	Middle	Last		
George John Clark					
4. DATE OF DEATH	Month	Day	Year		
	3 - 3	19	19		
5. SEX	6. COLOR OR RACE	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. B. DATE OF BIRTH	8. AGE (in years lost birthday)	9. IF UNDER 1 YEAR IF UNDER 24 HRS
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	08 31 1885	73 yrs	Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Machinist		Soap		Roxanna MD U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Eugene Clark		McEvire			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Heart Failure			
420.1 DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		Acute Myocardial Infarction			
(b) DUE TO		Gen. arteriosclerosis			
(c) DUE TO		Deobstructive arteritis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1951, 19, to 19, 19, that I last saw the deceased alive on Feb 25, 19, and that death occurred at 10:30 AM, from the causes and on the date stated above		ADDRESS (Street, city or town, state) Severna Park DATE SIGNED 3-3-59			
ACTUAL SIGNATURE Robert B. Hahn MD					
PHYSICIAN'S NAME (Type) Robert B. Hahn					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/6/59	22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill		22d. LOCATION (City, town, or county) (State) Anne Arundel md	
23. FUNERAL DIRECTOR'S SIGNATURE John Dugger		ADDRESS Glen Burnie Md		24a. REC'D BY REGISTRAR Date MAR 5 '59	
				24b. REGISTRAR'S SIGNATURE Edith E. Hahn	



H HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2, and be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2650

CERTIFICATE OF DEATH

Reg. Dist. No. 02604

1. PLACE OF DEATH a. COUNTY <i>A.R.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn.</i>		c. LENGTH OF STAY IN 1b <i>50</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>206 Academy Rd</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn.</i>	
3. NAME OF DECEASED (Type or print) <i>Clarence L. Clayton, Jr.</i>		d. STREET ADDRESS <i>206 Academy Rd</i>	
4. DATE OF DEATH <i>3-1-59</i>		5. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. SEX <i>M</i>	7. COLOR OR RACE <i>W</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH <i>1/8/98.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tire fitter</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>BLFJ.</i>	11. BIRTHPLACE (State or foreign country) <i>Ind.</i>	12. CITIZEN OF WHAT COUNTRY? <i>Address</i>
13. FATHER'S NAME <i>James.</i>	14. MOTHER'S MAIDEN NAME <i>Margaret Spero</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>	
16. SOCIAL SECURITY NO <i>422-1</i>	17. INFORMANT <i>Family Name</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> DUE TO <i>ASCVD</i> DUE TO <i>Pulm Engphr & Fibrom</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>28 Feb 59</i> <i>1 Mar 59</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D.</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Apr</i> , 1957, to <i>March</i> , 1959, that I last saw the deceased alive on <i>28 Feb 59</i> , 1959, and that death occurred at <i>1:15 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Andrew Sushowski</i> PHYSICIAN'S NAME (Type) <i>Andrew R. Sushowski M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>3/4/59.</i>	22b. DATE THEREOF <i>3/4/59.</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>See below</i>	ADDRESS <i>130 E. Fort Ave.</i>	24a. REC'D BY REGISTRAR DATE <i>MAR 4 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur B. Price</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician, to FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02605					
2651 Item 1 Rev. 1-29 5-16-55 et										Reg. Dist. No.					
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY <i>A.A.</i>					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md.</i>					b. COUNTY <i>A.A.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lothian</i>			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hillsmere Shores</i>			d. STREET ADDRESS <i>Box 356 R. 4 D. 3 Annapolis</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Moreland Nursing Home</i>					f. DATE OF DEATH <i>Mar 6 1959</i>										
3. NAME OF DECEASED (Type or print)		First <i>Clarence</i>	Middle <i>Lee</i>	Last <i>Cowles</i>	4. DATE OF DEATH <i>Mar 6 1959</i>		Month <i>Mar</i>	Day <i>6</i>	Year <i>1959</i>						
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-4-1872</i>		9. AGE (In years at birthday) <i>86 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supt of Schools</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>Supt of Schools</i>			11. BIRTHPLACE (State or foreign country) <i>Vermont</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Albert Lee Cowles</i>					14. MOTHER'S MAIDEN NAME <i>Mary Whitney</i>										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.					17. INFORMANT <i>William G. Husted</i> 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) <i>coronary occlusion</i>										INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Postured high (old) -</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Hour o. m. p. m.		Month <i>Sept</i>	Doy <i>19</i>	Year	20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Lothian</i>		(County) <i>Anne Arundel</i>	(State) <i>Md.</i>			
21. I certify that I attended the deceased from <i>Sept 1, 1957</i> , to <i>Mar 6, 1959</i> , that I last saw the deceased alive on <i>Mar 1, 1958</i> , and that death occurred at <i>2:15 A.M.</i> from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <i>Lothian Md.</i>		DATE SIGNED <i>3-6-59</i>			
ACTUAL SIGNATURE <i>Emily H. Wilson</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>								22b. DATE THEREOF <i>3-7-59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>EMILY H WILSON</i>		22d. LOCATION (City, town, or county) <i>Frasburg</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor, Sr.</i>		24a. ADDRESS <i>Annapolis Md.</i>								24b. REC'D BY REGISTRAR DATE <i>MAR 11 '59</i>		24c. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>			



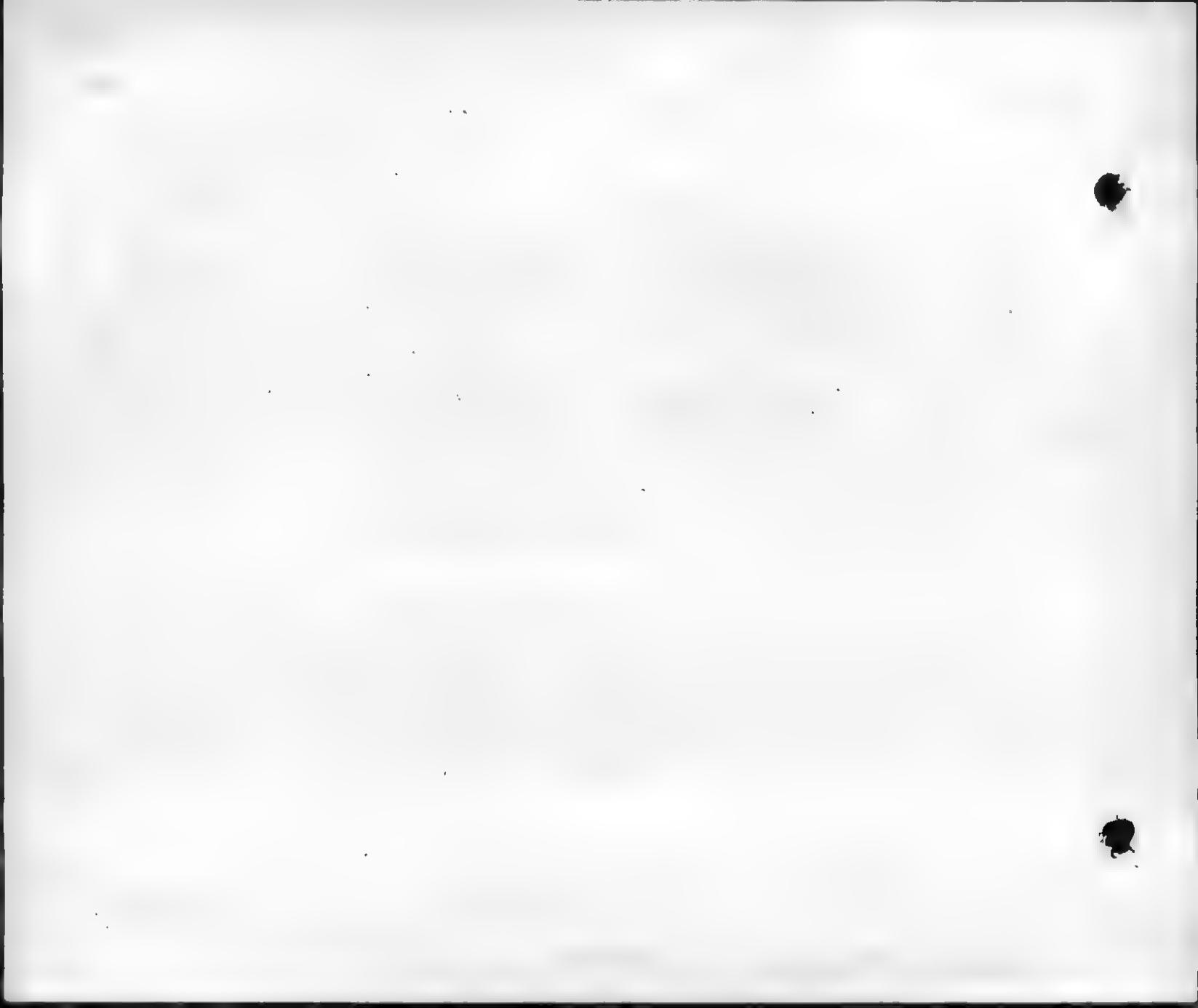
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2600

CERTIFICATE OF DEATH

Reg. Dist. No. 02606

1. PLACE OF DEATH a. COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased resided, if institution, residence before admission)		o. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town)		b. COUNTY A.A.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		823 Spa Road		d. STREET ADDRESS		823 Spa Road		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	DATE OF DEATH	Month	Day	Year
4. SEX		5. COLOR OF HAIR	6. COLOR OF EYES	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years (or birthday) yrs.)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days
Female		Col.	Col.	3-27-1872	86	3	14	1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Housewife				A.A. Co. Md.		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
John Hawkins		Francesca Smith						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No, or Unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		INFORMANT		Address		
No		—		Maggie Creek - Annapolis, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		DUE TO		INTERVAL BETWEEN ONSET AND DEATH		
		47:1		Congestive Cardiac Failure		2 day		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		{ (b)		DUE TO				
		{ (c)						
PART II. OTHER THAN FATAL CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from 3-14-59, 19, to 3-14-59, 19, that I last saw the deceased alive on 3-14-59, 19, and that death occurred at 4:18 M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED
ACTUAL SIGNATURE		K. Alley		M.D. 42 Calhoun St		Annapolis, Md.		3-14-59
PHYSICIAN'S NAME (Type)		A.T. Alley						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)
Burial		3-18-59		Brewer Hill		Annapolis, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
William Geese Jr - Annapolis, Md.				MAR 18 59		W. W. & Thomas		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02607

CERTIFICATE OF DEATH

Reg. Dist. No.

2601

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		b. COUNTY Anne Arundel	
c. LENGTH OF STAY IN 1b 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle	Last Crowner
4. DATE DEATH	Month March	Day 26	Year 1959
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 77 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME <i>William J. Crowner</i>	14. MOTHER'S MAIDEN NAME <i>Anne Arundel Crowner</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	INFORMANT	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446 X Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <i>Arterio-occlusive Myeloneuro-</i> (c) <i>Vascular disease</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>March 10, 1959</i> to <i>March 26, 1959</i> , that I last saw the deceased alive on <i>March 26, 1959</i> , and that death occurred at <i>12:40 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. L. Hubbard</i>	ADDRESS (Street, city or town, state) <i>10 E. Clay St., Baltimore, Md.</i>		DATE SIGNED <i>March 31, 1959</i>
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/29/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Crown Cemetery</i>	22d. LOCATION (City, town, or county) <i>Galesville Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pauline H. Anna</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>MAR 31 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician, or detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death. Page 4

VS A15 (4)
1SM 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02608

2602

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if not in hospital before admission) a. STATE				
Anne Arundel MARYLAND		Maryland Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN TB	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Annapolis		Annapolis				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS					
107 Clay St.	107 Clay St.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First	Middle	Last			
John	E	Davis				
4. DATE OF DEATH	Month	Day	Year			
3	2	1959				
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
Male	Col.		7-4-1894	64 yrs.	7 28	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
Retired		218 Naval Acad. East Fort, Md.		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?		
Vergil Davis		Mary Peel		U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		INFORMANT		Address
Yes / W.W.I				Jessie Davis - Annapolis, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Caused Coronary Thrombosis				
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		Colonary artery disease				
(b) DUE TO						
(c) DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May</u> , 1959, to <u>March 2</u> , 1959, that I last saw the deceased alive on <u>March 2</u> , 1959, and that death occurred at <u>11:29 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)				
ACTUAL SIGNATURE R. P. Richard Davis		DATE SIGNED M.D. 110 - Clay Street Annapolis, Md. 3/2/59				
PHYSICIAN'S NAME (Type)						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
Burial		3-5-59	Brewer Still		Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE	
William Reese, Jr. - Annapolis, Md.				3/2/59	Arthur S. Morris	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02609

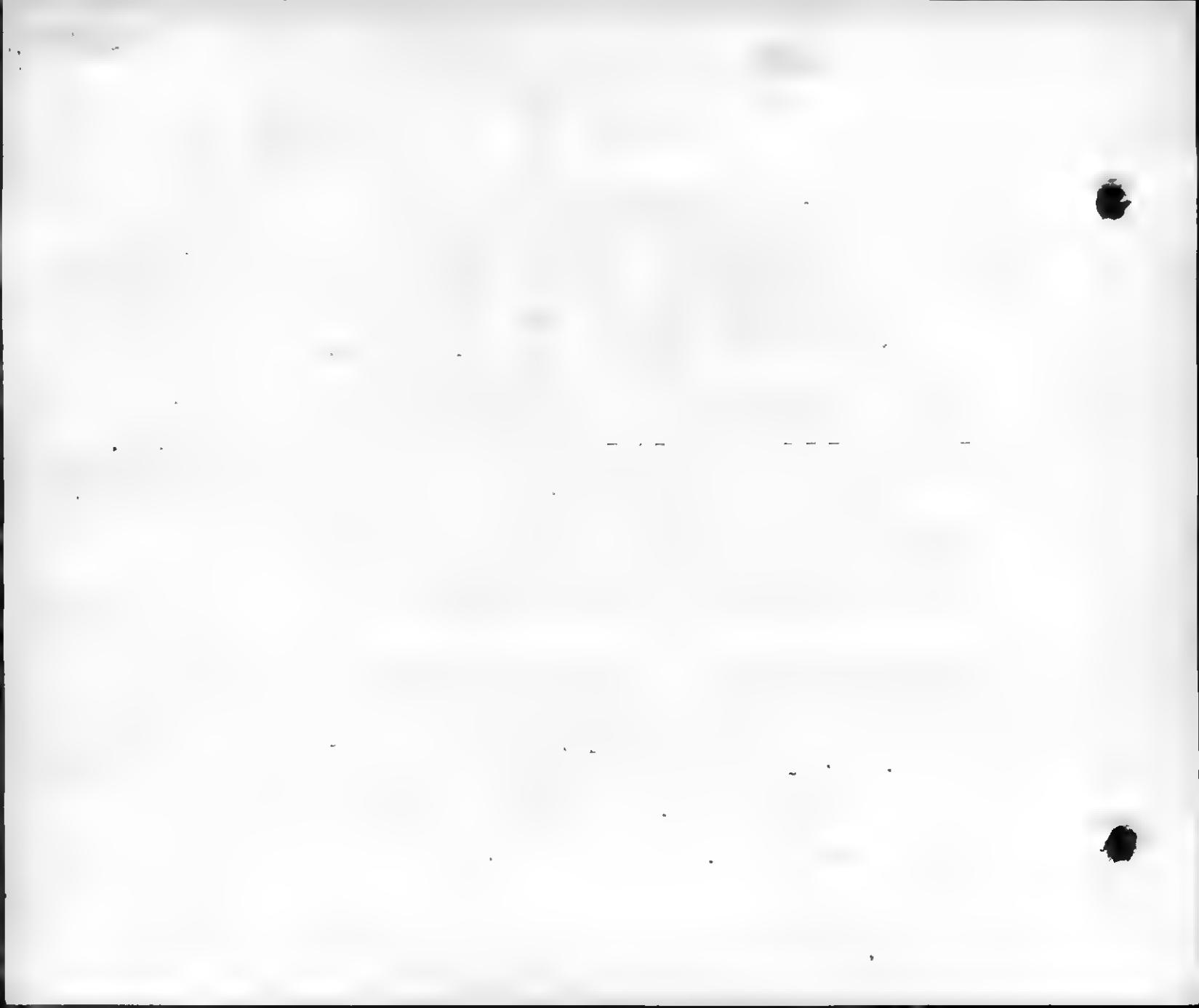
2603

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Anne Arundel General Hospital		d. STREET ADDRESS Box 337	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MICHAEL	Middle	Last Dawson
4. DATE DEATH	Month March	Day 4	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1959
9. AGE (In years lost birthday) yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
30	3	30	30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Donald Stewart Dawson		14. MOTHER'S MAIDEN NAME Dora Antoinette Koogle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. INFORMANT Mother	
17. ADDRESS		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Renal artery</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH 5 hours	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-4-59, 19, to 3-4-59, 19, that I last saw the deceased alive on 3-4-59, 19, and that death occurred at 11 AM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Albert L. Anderson</i>		ADDRESS (Street, city or town, state) M.D.	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
Albert L. Anderson MD		44 Southgate Ave. Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 5, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Mayo Memorial Cemetery	22d. LOCATION (City, town, or county) Mayo, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Hopping</i>	ADDRESS HOPPING FUNERAL HOME	24a. REC'D BY REGISTRAR DATE MAR 9 '59	24b. REGISTRAR'S SIGNATURE <i>John Hopping</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02610

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>A.A.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A.A. General Hospital</i>		d. STREET ADDRESS <i>1214 Grant St</i>				
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Milton</i>		First <i>Milton</i>	Middle <i></i>			
4. DATE OF DEATH <i>3-30 1959</i>	Month <i>3</i>	Day <i>30</i>	Year <i>1959</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 19-1874</i>			
9. AGE (in years last birthday) <i>84</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>			
13. AGE (in years last birthday) <i>84</i>	14. BIRTHPLACE (State or foreign country) <i>Mayo Md</i>	15. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	16. PARENT'S NAME <i>Joseph J. Dawson</i>			
17. MOTHER'S MADDEN NAME <i>McKinnon</i>	18. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or unknown) <i>No</i>	19. SOCIAL SECURITY NO. <i></i>	20. INFORMANT <i>Enola L Dawson (2)</i>			
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>475X</i> DUE TO INTERVENING, 8 ft long		INTERVAL BETWEEN ONSET AND DEATH <i>1 min</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Mayo</i>	20f. (City or town) <i>Mayo</i>	(County) <i></i>	(State) <i>Md</i>
21. I certify that I attended the deceased from <i>March 28 1959 to March 30 1959</i> , that I last saw the deceased alive on <i>March 30 1959</i> , and that death occurred at <i>10 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>121 Cultural St, Annapolis, Md.</i>		DATE SIGNED <i>3/31/59</i>		
ACTUAL SIGNATURE <i>John L. Hardin</i>						
PHYSICIAN'S NAME (Type) <i></i>						
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-1-59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Mayo Cemetery</i>	22d. LOCATION (City, town, or county) <i>Mayo</i>		(State) <i>Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md</i>	24a. REC'D BY REGISTRAR DATE <i>APR 2 '59</i>	24b. REGISTRAR'S SIGNATURE <i>John S. Knott</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2605

CERTIFICATE OF DEATH

Reg. Dist. No.

02611

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. J. General</i>		d. STREET ADDRESS <i>800 Boucher Ave</i>	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Susan</i>	Middle <i>A.</i>	Last <i>Defenbaugh</i>
4. DATE OF DEATH	Month <i>3</i>	Day <i>6</i>	Year <i>1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 5 1876</i>
9. AGE (In years from birthday) yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	12. BIRTHPLACE (State or foreign country) <i>Lambbridge Md</i>
13. FATHER'S NAME <i>Unknown</i>	14. MOTHER'S MAIDEN NAME <i>Sarah Dail</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>9-40</i>	16. SOCIAL SECURITY NO.
17. INFORMANT <i>Mrs Russell E. Hallock</i>	Address <i>2</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i> 3/4/59 2 days DUE TO <i>Thrombosis? Hemorrhage? cerebral</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Deviil changes - fractured left limb</i> DUE TO <i>aged - semibehemo - cardiovascular disease</i> (c) <i>Deviil changes - fractured left limb</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Deviil changes - cardiovascular disease</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>In her home, fractured left limb</i>		
20c. TIME OF INJURY Month, Day, Year <i>3:30 p.m. 2-24-1959</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State) <i>Annapolis Anne Arundel Md</i>
21. I certify that I attended the deceased from <i>Feb 24</i> , 1959, to <i>March 6</i> , 1959, that I last saw the deceased alive on <i>March 6</i> , 1959, and that death occurred at <i>4:25 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>96 Cathedral St, Annapolis Md</i>			
ACTUAL SIGNATURE <i>Harold R. Bobbman M.D.</i>	DATE SIGNED <i>3/9/59</i>		
PHYSICIAN'S NAME (Type) <i>Harold R. Bobbman M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-9-59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Edwards Chapel</i>	22d. LOCATION (City, town, or county) (State) <i>Carole Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor Sons</i>	ADDRESS <i>Annapolis Md</i>	24a. REC'D BY REGISTRAR DATE <i>MAR 11 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Tress</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02612

CERTIFICATE OF DEATH

Reg. Dist. No.

2606

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY H.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pasadena		d. STREET ADDRESS Route 5, Box 61	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION A.A. General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Rena	Middle L.	Last Despeaux	4. DATE OF DEATH March	Month March	Day 29	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6, 1891	9. AGE (In years lost birthday) 67 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY State Hospital		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Crawford		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT 217-22-0476 Charles Despeaux, Jr., Rt. 5, Box 61, Pasadena, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 331X		Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 20 months			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b) Hypertensive vascular disease		10 years			
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)					
20c. TIME OF INJURY Hour p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1955, to March 29, 1959, that I last saw the deceased alive on March 29, 1959, and that death occurred at 1:35 p.m., from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 3-29-59	
ACTUAL SIGNATURE <i>Edward S. Bock</i>		MD 41 Southgate Avenue					
PHYSICIAN'S NAME (Type) Edward S. Bock		Annapolis, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-2-59		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		22d. LOCATION (City, town, or county) Baltimore (State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 3 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the register for burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02613

2652

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTRY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Odenton</i>		c. LENGTH OF STAY IN 1b <i>10 yrs.</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OR INSTITUTION <i>Annapolis Road</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Odenton</i>	
f. STREET ADDRESS <i>Annapolis Road</i>		g. STREET ADDRESS <i>Annapolis Road</i>	
h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Andrew</i>		First <i>J.</i>	Middle <i>Disney Jr.</i>
4. DATE OF DEATH <i>March 29, 1959</i>		Month <i>March</i>	Day <i>29</i> Year <i>1959</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Dec. 21-1872</i>		9. AGE (In years from birth) <i>86 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Blacksmith-Helping B & A P.R.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>B & A P.R.</i>	10c. BIRTHPLACE (State or foreign country) <i>Anne Arundel Co., Md.</i>
11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Andrew J. Disney - Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Harriett K. Redmiles</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>123-45-6789</i>	
17. INFORMANT <i>Kenneth L. Disney - Same as No. 2</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (d) <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) <i>Bentley</i>	
		INTERVAL BETWEEN ONSET AND DEATH <i>1-7-59</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Death Visited to son</i>	
20a. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>5117 37th St. Bldg. 1</i>	
20c. (County) <i>Baltimore</i>		(State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>Dec. 21-1958</i> to <i>Mar. 29, 1959</i> , that I last saw the deceased alive on <i>Apr. 28, 1959</i> , and that death occurred at <i>5117 37th St. Bldg. 1</i> , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>5117 37th St. Bldg. 1</i>			
DATE SIGNED <i>3-29-59</i>			
ACTUAL SIGNATURE <i>John L. Disney</i>		PHYSICIAN'S NAME (Type) <i>John L. Disney</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/31/59</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Friendship Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Anne Arundel - Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John L. Disney</i>		24a. REC'D BY REGISTRAR DATE <i>Arthur S. Krause APR 1 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02614

2607

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANAPOLIS		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X GAMBRILLS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL HOSPITAL		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANCES		First Middle Last FRANCES DOLJAN		4. DATE OF DEATH MARCH 11 1959		Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1881	9. AGE (In years lost birthday) 77 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Joseph Doljan Jr		Address Son Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		DUE TO Intrinsic disease of heart		Congestive Heart Failure Intrinsic disease Cardio Vasculon disease		INTERVAL BETWEEN ONSET AND DEATH 2 wks. yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>Mar 4</u> , 1959 to <u>March 11, 1959</u> that I last saw the deceased alive on <u>March 11</u> , 1959, and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Maurice F. Klawans</i>		ADDRESS (Street, city or town, state) DATE SIGNED March 12, 1959					
PHYSICIAN'S NAME (Type) Maurice F. Klawans MD		31 Southgate Ave. Annapolis, Md.					
22a. BURIAL, CREMATION BURIAL		22b. DATE THEREOF 3-14-1959	22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Cemetery		22d. LOCATION (City, town, or county) Annapolis, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR D 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial trust permit.

VS AISC 155-10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

2653 Item 4 FilmG239 3-15-59 et

Reg. Dist. No.

112615

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Anne Arundel MARYLAND		STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	
TOWN GLEN BURNIE		3 months	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 204 CARROLL Rd.		STREET 419 S. BENTALOY ST.	
(If rural give location)			
3. NAME OF (First) Lola Gertrude Dorsey (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH March 8, 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed	8. DATE OF BIRTH JANUARY 12, 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Douglas Martin		14. MOTHER'S MAIDEN NAME Margaret Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS ALMER DORSEY 419 S. BENTALOY ST.		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 1 X IMMEDIATE CAUSE (A) Calcemoneous Pancreas ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 4 Weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M. <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> of work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11/20, 1958, to 3/8, 1959, that I last saw the deceased alive on 3/7, 1959, and that death occurred at 11 A.M. from the causes and on the date stated above. SIGNATURE <i>Almer Dorsey</i> ADDRESS (Street, city, town, state) <i>419 S. BENTALOY ST. BALTIMORE, MD</i> DATE SIGNED <i>3/9/59</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 3/11/59 NAME OF CEMETERY OR CREMATORIAL WOODLAWN LOCATION (City, town, or county) WOODLAWN MD	
24. REC'D BY REGISTRAR MAR 11 '59		REGISTRAR'S SIGNATURE Arthur S. Evans	
25. FUNERAL DIRECTOR'S SIGNATURE <i>Geo. L. Schupp</i> ADDRESS <i>Baltimore, Md. Schupp 2101 Frederick Ave</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2654

CERTIFICATE OF DEATH

02616

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riva		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riva Nursing Home		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) FIODA		4. DATE OF DEATH MARCH 4 1959	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
10c. FATHER'S NAME SIRAS BROWN		11. BIRTHPLACE (State or foreign country) Haynesburgh, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. MOTHER'S MAIDEN NAME Unknown	
14. ADDRESS Same as #2		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mr Harry Dull Sr - Son	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. b) DUE TO c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 60 Hours Unknown	
CEREBRAL THROMBOSIS GENERALIZED ARTERIOSCLEROSIS		Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>15 Jan 1959</u> to <u>5 MARCH 1959</u> , that I last saw the deceased alive on <u>5 MARCH 1959</u> , and that death occurred at <u>11A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Annapolis, Maryland DATE SIGNED Edward S. Beck, M.D.			
ACTUAL SIGNATURE <i>Edward S. Beck</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF March 7, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Cedar Bluff	
22d. LOCATION (City, town, or county) Annapolis, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOPHIG FUNERAL HOME		24a. ADDRESS Annapolis, Maryland 172 West St.	
24b. REC'D BY REGISTRAR Arthur S. Kraus		24c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 or 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5, 6, and 7 with the State Board of Health.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and is any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02617

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN lb X EDGEWATER	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ANNE ARUNDEL		d. STREET ADDRESS Mt Stewart Farm	
e. IS RESIDENT ON A FARM YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES RINGGOLD DUVALL		First	Middle
4. SEX Male	5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	7. DATE OF BIRTH Feb. 17, 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Edgewater, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RINGGOLD DUVALL		14. MOTHER'S MAIDEN NAME MARY WILLARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. none	
17. INFORMANT		Address Steele Ave.	
E. Saunders Duvall—Brother—Annapolis, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)		INTERVAL BETWEEN ONSET AND DEATH 9 days.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 916.0		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	
DUE TO		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) attempting to put out brush fire.	
20c. TIME OF INJURY Hour p. m. 3 - 19 - 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bunce	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Elmer G. Linhardt MD		DATE SIGNED 	
22a. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify) Burial March 30, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Salem Cemetery	
22d. LOCATION (City, town, or county) (State) Annapolis, Maryland		24a. REC'D BY REGISTRAR APR 1 '59	
22e. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	
ADDRESS Annapolis, Md.			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2655

CERTIFICATE OF DEATH

Reg. Dist. No.

02618

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. Geo. G. Meade		c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 425 Thompson Ave		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USA Ft. Geo. G. Meade, Md						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) (Infant)Donald		First R.	Middle .	Last Engle	4. DATE OF DEATH March 24 1959	Month March	Day 24	Year 1959
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 March 1959	9. AGE (In years from last birthday) yrs. Months	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Days	11. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME Donald R Engle		14. MOTHER'S MAIDEN NAME Patricia J. Stuckey						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Donald R. Engle, 425 Thompson Ave, Severn, Md		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Asphyxia				INTERVAL BETWEEN ONSET AND DEATH		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.				Micrognathia				
(b) DUE TO Pierre Robin Syndrome - Cleft Palate				Glossotropism				
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month March 19	Day Year 1959	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Severn	(County) Anne Arundel	(State) Md
21. I certify that I attended the deceased from 24 March 1959, to 24 March 1959, that I last saw the deceased alive on 24 March 1959, and that death occurred at 5:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE Frederick W. Tafferty, M.D.		3/24/59						
PHYSICIAN'S NAME (Type) FREDERICK W. TAFFERTY Captain MC		U. S. ARMY HOSPITAL, FT MEADE, MD						
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 3-27-59		22c. NAME OF CEMETERY OR CREMATORIUM Springfield Cemetery		22d. LOCATION (City, town, or county) Springfield, Ohio (State)		
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Koenig		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please file carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2609

CERTIFICATE OF DEATH

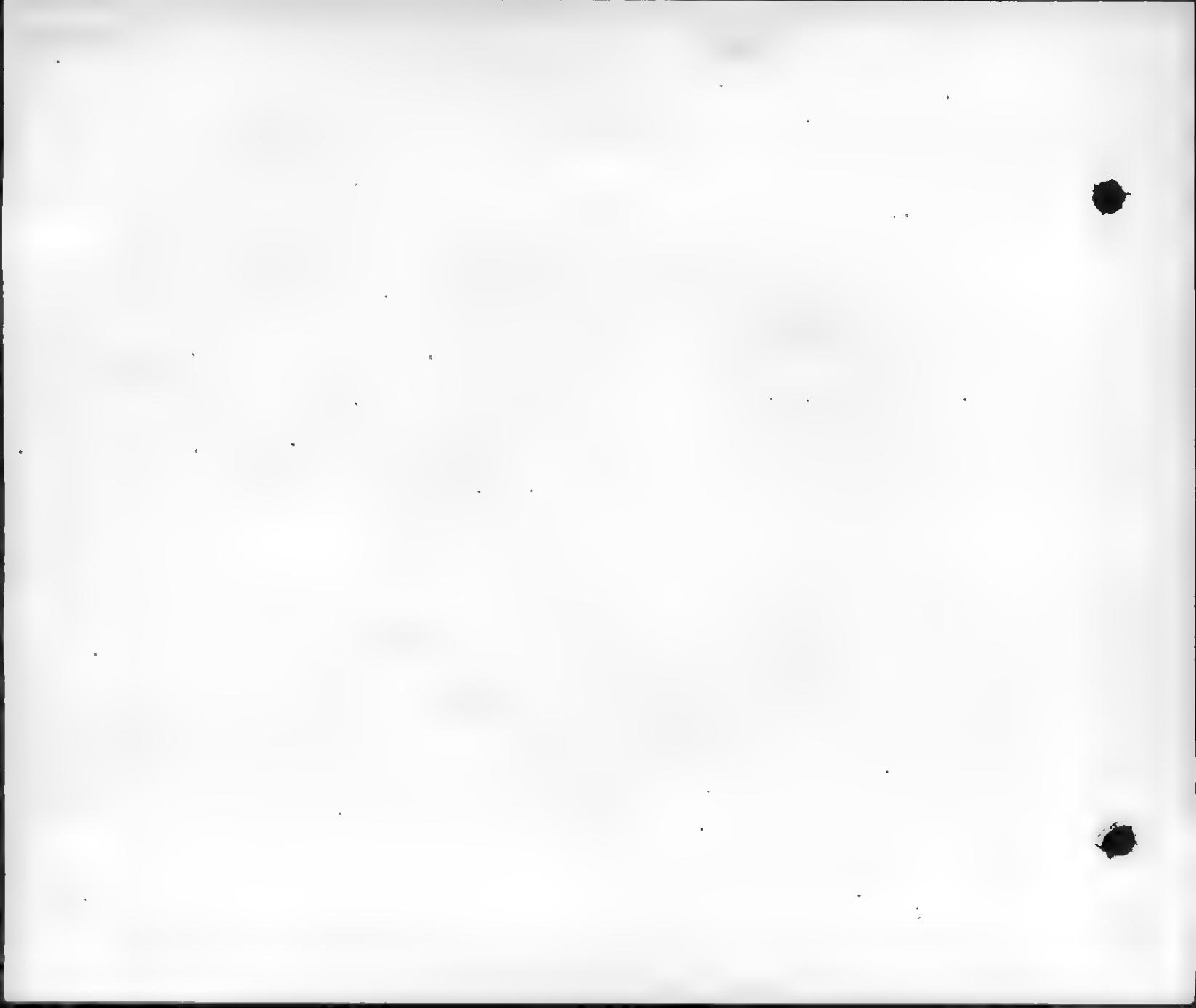
Reg. Dist. No.

02619

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis		d. STREET ADDRESS 415 Chester Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Female	Negro	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	Forrester	March	18	19 59
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. INH. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Bernard Albert Forrester				14. MOTHER'S MAIDEN NAME Doris Pauline Booth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address	
Mother, 415 Chester Ave., Annapolis, Md.							
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 18, 1959 , to March 18, 1959 , that I last saw the deceased alive on March 18, 1959 , and that death occurred at 1:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 95 Cathedral St. DATE SIGNED 3/24/59							
ACTUAL SIGNATURE Neil L. Lewis, M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-24-59		22c. NAME OF CEMETERY OR CREMATORIAL Brewer Hill		22d. LOCATION (City, town, or county) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Reese #108 Wash St. Annapolis, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thorne	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2610

CERTIFICATE OF DEATH

Reg. Dist. No.

02620

1. PLACE OF DEATH a. COUNTY <i>aa</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>General</i>		d. STREET ADDRESS <i>41 Murray Ave</i>	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Clarence E. Fouche</i>		First <i>E.</i>	Middle <i></i>
4. DATE OF DEATH <i>MARCH 14 1951</i>		Last <i></i>	Month <i>MARCH</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>June 14 1885</i>		9. AGE (In years lost birthday) <i>23 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Plumber</i>	11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John R. Fouche</i>	
14. MOTHER'S MAIDEN NAME <i>Annie R. Medford</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Ella M. Fouche (2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Clents mycotic infection</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 minutes</i>	
DUE TO (b) <i>Coronary artery atherosclerosis</i>		5 gr.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (c) <i>None</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>Annapolis</i>
21. I certify that I attended the deceased from <i>Sept. 1952</i> to <i>March 1951</i> , that I last saw the deceased alive on <i>March 1951</i> , and that death occurred at <i>Annapolis Md</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>John R. Fouche</i> ADDRESS <i>121 Corkscrew</i> DATE SIGNED <i>3/6/51</i>		ADDRESS (Street, city or town, state) <i>Annapolis Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-9-59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Hillcrest Cemetery</i>
22d. LOCATION (City, town, or county) <i>Annapolis</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor Saco</i>		ADDRESS <i>Annapolis Md.</i>	24a. REC'D. BY REGISTRAR DATE <i>MAR 7 1959</i>
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Reed</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2656

CERTIFICATE OF DEATH

02621

Reg. Dist. No.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 2mo 10days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eaton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS Unknown		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle 	Last Fountain	4. DATE OF DEATH	Month 3	Day 4	Year 19 59
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1880	9. AGE (In years lost birthday) 78	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS Days 	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO 214-10-0613		17. INFORMANT Hospital Records		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>5/11/55</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) <i>Post Surgical — Intestinal Obstruction</i> <i>Inter Trachanteric Fracture Right Hip</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? <i>Max Pulmonary Tuberculosis — Senility — Syphilis</i> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Hour a. m. ----- p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) -----	(County) 	(State) 		
21. I certify that I attended the deceased from 12/24, 1958 to 3/4/59 , 19, that I last saw the deceased alive on 3/4/59 , 19, and that death occurred at 10:30P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i>	M.D.	ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.		DATE SIGNED 3/5/59			
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.	Crownsville State Hospital, Md.		3/5/59				
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial 1/25/59	22b. DATE THEREOF 1/25/59	22c. NAME OF CEMETERY OR CREMATORIUM Locust Chapel	22d. LOCATION (City, town, or county) Locust Chapel	(State) -----			
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. V. Moore & Son, Inc.</i>	ADDRESS Huntington, Md.	24a. REC'D BY REGISTRAR DATE 1/23/59	24b. REGISTRAR'S SIGNATURE Arthur S. Krause				



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2611

CERTIFICATE OF DEATH

Reg. Dist. No.

02622

1. PLACE OF DEATH a. COUNTY <i>aa</i>		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>129 Monticello Ave</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William Henry French</i>		First	Middle
4. DATE OF DEATH <i>Dec 21-1894</i>		Last	Month 3
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Dec 21-1894</i>		9. AGE (In years from birthday) <i>64</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mgr. Circulation Dept.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Newspaper Business</i>	
11. BIRTHPLACE (State or foreign country) <i>Norfolk Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William H. French</i>		14. MOTHER'S MAIDEN NAME <i>Minnie Woolhiser</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>World War</i>	
17. INFORMANT <i>Lillie L. French</i>		Address <i>2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>CORONARY THROMBOSIS</i> DUE TO (c) <i>ATHEROSCLEROTIC CORONARY ART. DIS.</i> <i>extensive</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>HYPERTENSION, MODERATE</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2/16</i> , 19 <i>59</i> , to <i>3/6</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>3/2</i> , 19 <i>59</i> , and that death occurred at <i>10 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Edward S. Beck</i>			
ADDRESS (Street, city or town, state) <i>M.D. 41 Southgate Ave Norfolk Va</i>			
DATE SIGNED <i>3/7/59</i>			
22c. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Mar-9-59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Grove</i>		22d. LOCATION (City, town, or county) <i>Norfolk</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		23. ADDRESS <i>Annapolis Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>MAR 11 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2657

CERTIFICATE OF DEATH

02623

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE Maryland		b. COUNTY Baltimore City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 29 yrs. 2 mo. 10 d		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore,		d. STREET ADDRESS 826 Tessier Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Ida		First	Middle	4. DATE DEATH 1882	Month 3	Day 20	Year 1959	
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1882	9. AGE (In years lost birthday) 77 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Houseworker		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME John Cole				14. MOTHER'S MAIDEN NAME Sarah				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Senile Atrophy								
DUE TO Generalized Arteriosclerosis								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cellulitis of the Right Hand								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----						
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) ----- (County) ----- (State) -----		
21. I certify that I attended the deceased from 1/10 , 19 50 , to 3/20 , 19 59 , that I last saw the deceased alive on 3/20 , 19 59 , and that death occurred at 12:45 P.M. , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>L. Benedict, M. D.</i>		ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.						DATE SIGNED 3/20/59
PHYSICIAN'S NAME (Type) L. Benedict, M. D.		Crownsville State Hospital, Md.						3/20/59
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 3-26-59		22c. NAME OF CEMETERY OR CREMATORIUM Anatomy Board of Md., Baltimore, Md.		22d. LOCATION (City, town, or county) Baltimore, Md. (State) -----		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Pease II</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 2 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>		

20.1.1968

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 so it can be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2612

CERTIFICATE OF DEATH

Reg. Dist. No. 02624

1. PLACE OF DEATH a. COUNTY <i>A. A.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>O. H. General Hospital</i>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME DECEASED (Type or print) <i>Helen Bain</i>	First <i>Helen</i>	Middle <i>Bain</i>	Last <i>Gray</i>
4. DATE OF DEATH <i>3-29-59</i>	Month <i>3</i>	Day <i>29</i>	Year <i>1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 29-1900</i>
9. AGE (In years last birthday) <i>58</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Scotland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>Robert Bain</i>	14. MOTHER'S MAIDEN NAME <i>Helen Seth</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO <i>199-2</i>	17. INFORMANT <i>John Gray</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of colon</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 1, 1955</i> , to <i>March 21, 1959</i> , that I last saw the deceased alive on <i>March 21, 1959</i> , and that death occurred at <i>12:45 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Helen Bain</i> M.D. <i>151 Charles St. 7-1111</i> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Apr 1-59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Hillcrest Cemt.</i>	22d. LOCATION (City, town, or county) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>	ADDRESS <i>Annapolis Md</i>	24a. REC'D BY REGISTRAR DATE <i>APR 2 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2613

CERTIFICATE OF DEATH

02626

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 513 1st St.		d. STREET ADDRESS 33 EASTERN Ave.	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First SUSAN	Middle K.	4. DATE OF DEATH Hancock 3 27 1959
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-28-1881
9. AGE (In years last birthday) yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. KIND OF BUSINESS OR INDUSTRY HOME	12. BIRTHPLACE (State or foreign country) Kentucky
13. FATHER'S NAME ANDREW J. Meuth	14. MOTHER'S MAIDEN NAME KATHERINE HOOVER	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO 17. INFORMANT WALTER Hancock #2
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 400.0		INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cystic Fibrosis		(c) Arteriosclerotic Heart Disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 4, 1959 to Jan 12, 1959 , that I last saw the deceased alive on 3-21-1959 , and that death occurred at 534 M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 65 Shaw St., Annapolis, Md.	
ACTUAL SIGNATURE James R. Martin	M.D.	DATE SIGNED 3/27/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-29-59	
22c. NAME OF CEMETERY OR CREMATORIAL CEDAR Bluff		22d. LOCATION (City, town or county) Annapolis Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR MAR 30 '59		24b. REGISTRAR'S SIGNATURE Carter & Hause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2614

CERTIFICATE OF DEATH

02627

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY a a. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY a a	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b RURAL and give nearest town	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 48 Franklin St		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
3. NAME OF DECEASED (Type or print) Jeanne		First	Middle
4. DATE OF DEATH 3 - 3		Month	Day
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Sept 21-1908
8. AGE (In years (last birthday) 50 yrs.		9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Elmer Martin Jackson Sr.		14. MOTHER'S MAIDEN NAME Blanche Beatrice Bower	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Robert J. Herron	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		b. DATE BETWEEN ONSET AND DEATH acute coronary heart disease 10 years	
b. (b) DUE TO cardiac strain			
c. (c) DUE TO Hypertension's			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-29-56, to 3-3-59, that I last saw the deceased alive on 2-16, 1959, and that death occurred at 27 M., from the causes and on the date stated above. ACTUAL SIGNATURE Edith R. Rodler M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) EDITH RODLER M.D. DATE SIGNED 3-3-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-6-59	
22c. NAME OF CEMETERY OR CREMATORIAL Academy Cent		22d. LOCATION (City, town, or county), Annapolis Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons		24a. REC'D BY REGISTRAR DATE MAR 9 '59	
ADDRESS Annapolis Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02628

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2615		Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN lb <u>9175 West St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9175 West St.</u>		d. STREET ADDRESS <u>9175 West St.</u>	
3. NAME OF DECEASED (Type or print) <u>Michael John Holland</u>		First	Middle
		Last	4. DATE OF DEATH
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>1-2-1955</u>	
10a. USUAL OCCUPATION (Give kind of work done d. Max. part of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md. U.S.A.</u>		9. AGE (in years last birthday) <u>4 yrs.</u>	
13. FATHER'S NAME <u>John Holland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Adele Randall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>None</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>John Holland, Annapolis, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burns generalized</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Burns</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>3</u> AM <u>18</u> 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>House</u>		20f. (City or town) <u>None</u>	
(County) <u>None</u>		(State) <u>None</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Holland</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F. L. Holland</u>		DATED/SIGNED <u>3/18/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-11-59</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) <u>Annapolis, Md.</u>	
22e. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis</u>		ADDRESS <u></u>	
24c. REC'D BY REGISTRAR <u>Arthur & Anna</u>		24d. REGISTRAR'S SIGNATURE <u>Arthur & Anna</u>	
DATE MAR 10 '59			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2616

CERTIFICATE OF DEATH

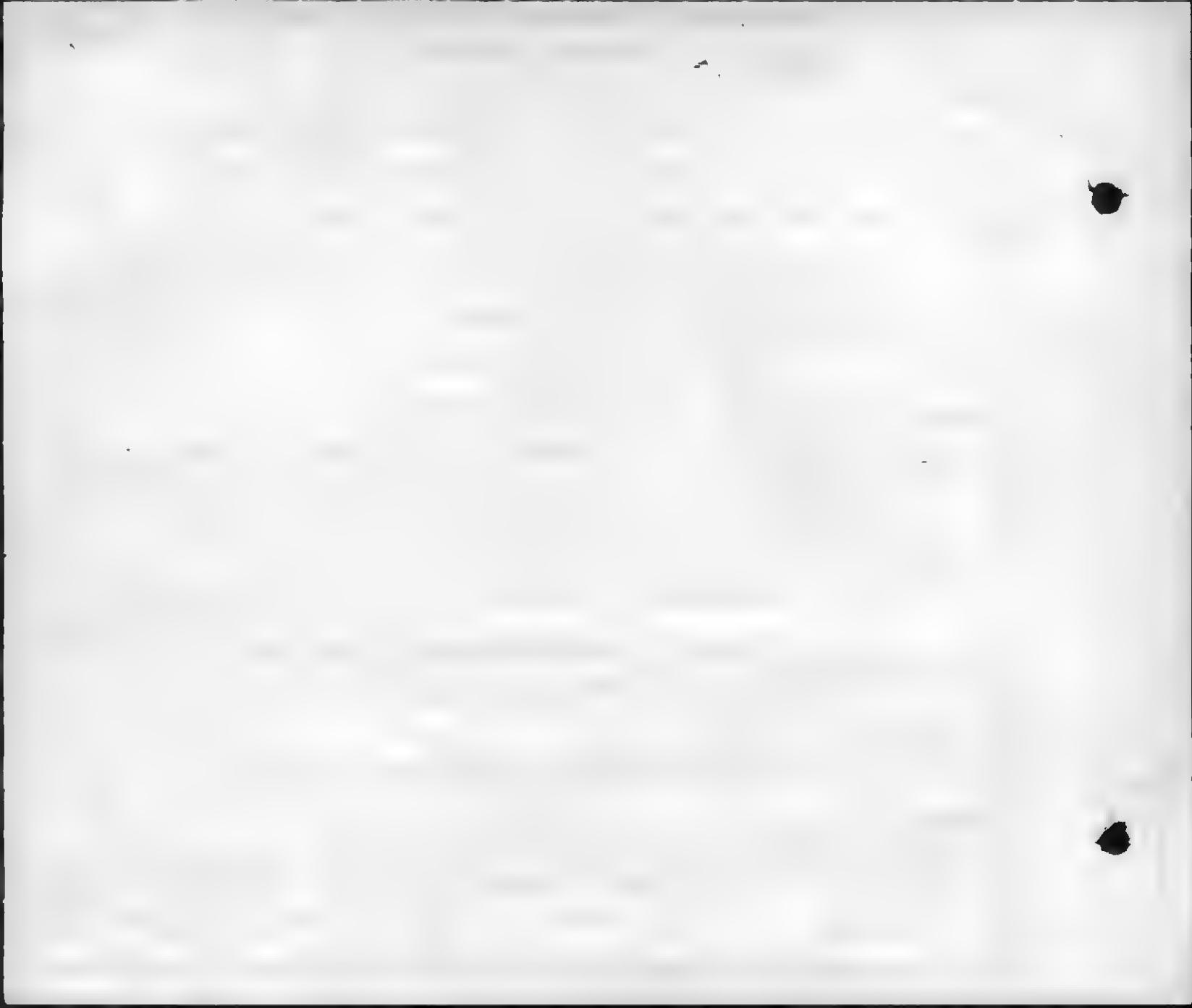
02629

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hanover</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmount</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hosp.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>NELLIE</u>		First <u></u>	Middle <u></u>
4. DATE OF DEATH <u>Holland</u>		Month <u>3</u>	Day <u>19</u> Year <u>1959</u>
S. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <u>WIDOWED</u> DIVORCED <input type="checkbox"/> <u>Aug 21 1880</u>	9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	10c. BIRTHPLACE (State or foreign country) <u>Maryland</u>
11. PARENT'S NAME <u>William Reville</u>		14. MOTHER'S MAIDEN NAME <u>Wmey Manner</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or discharge) <u>No</u>		16. SOCIAL SECURITY NO <u></u>	17. INFORMANT <u>James Holland Jr. Anne MD</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <u>Arteriosclerosis, Generalized</u> DUE TO (c) <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Hour o. m. <u>19</u>	Month <u></u>	Day <u></u>	Year <u></u>
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>		(County) <u></u> (State) <u></u>	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>52</u> , to <u>19 Mar.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>18 Mar 1959</u> , and that death occurred at <u>230A M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Beck M.D.</u>		ADDRESS (Street, city or town, state) <u>41 Southgate Ave.</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis MD</u>		DATE SIGNED <u>3/19/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-22-59</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>St. Andrew Cemetery Annapolis MD.</u>
22d. LOCATION (City, town, or county) <u></u>		(State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levi William Prince</u>		ADDRESS <u>Amherst</u>	24a. REC'D BY REGISTRAR DATE <u>MAR 23 '59</u>
			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02630

2658

Item 7 File No 240 3-6-59 et

Reg. Dist. No.

1. PLACE OF DEATH — COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Anne Arundel MARYLAND		STATE Same b. COUNTY Same	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
P.O. Glen Burnie		Same	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Route 1, Box 213, Lombardine Beach		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
Frank D. Hustak		Lost	4 DATE OF DEATH
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
Male W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Retired labor		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
FRANK HUSTAK		ANNA MATEJK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
NO		17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		Address	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		MARY SVEHLA, 909 N. COLLINGTON AVE.	
Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH Sudden	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		?	
(b) DUE TO General Arteriosclerosis			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 3/15/59	
EXAMINER'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
BURIAL		3-18-59	
23. FUNERAL DIRECTOR'S SIGNATURE		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
FR. OVACH & SON, 900 N. CHESTER ST. 5		22d. LOCATION (City, town, or county) (State)	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE MAR 17 '59		Clifford S. Traas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2659 CERTIFICATE OF DEATH

02631

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Seadore Rd.</i>		c. LENGTH OF STAY IN lb <i>—</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Seadore Rd.</i>		STREET ADDRESS <i>Deane Ave., Clarendon Village</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Deane Ave - Clarendon Village</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Joseph Ellrich</i>		First <i>Joseph</i>	Middle <i>Ellrich</i>	4. DATE OF DEATH <i>March 15, 1959</i>	Month <i>March</i>	Day <i>15</i>	Year <i>1959</i>		
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan. 11, 1904</i>			
				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <i>35 yrs</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Palomar (ret.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>B.C. Police Dept.</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Joseph Ellrich</i>		14. MOTHER'S MAIDEN NAME <i>Laura Johnson</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No, unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>318-07-6618</i>		17. INFORMANT <i>Mrs. Angelina Ellrich</i>		Address <i>Same as above</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>60X</i>		Acute coronary thrombosis <i>15 minutes</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>coronary insufficiency</i>		coronary insufficiency <i>several weeks</i>							
(c) DUE TO <i>Diabetes mellitus</i>		7 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>depressive noon</i>							
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Glen Haven</i>		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>March 1, 1959</i> to <i>March 15, 1959</i> , that I last saw the deceased alive on <i>March 14, 1959</i> , and that death occurred at <i>2:45 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>M.D. 800 S. Charles St., Baltimore, Md. March 15, 1959</i>						DATE SIGNED	
ACTUAL SIGNATURE <i>R.M. McLaughlin</i>		M.D. <i>R.M. McLaughlin</i>							
PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin M.D.</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>March 18, 1959</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven</i>		22d. LOCATION (City, town, or county) <i>Glen Haven, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Singleton Funeral Home</i>		ADDRESS <i>GLEN BURNIE, MD.</i>		24a. REC'D BY REGISTRAR <i>MAR 18 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>			



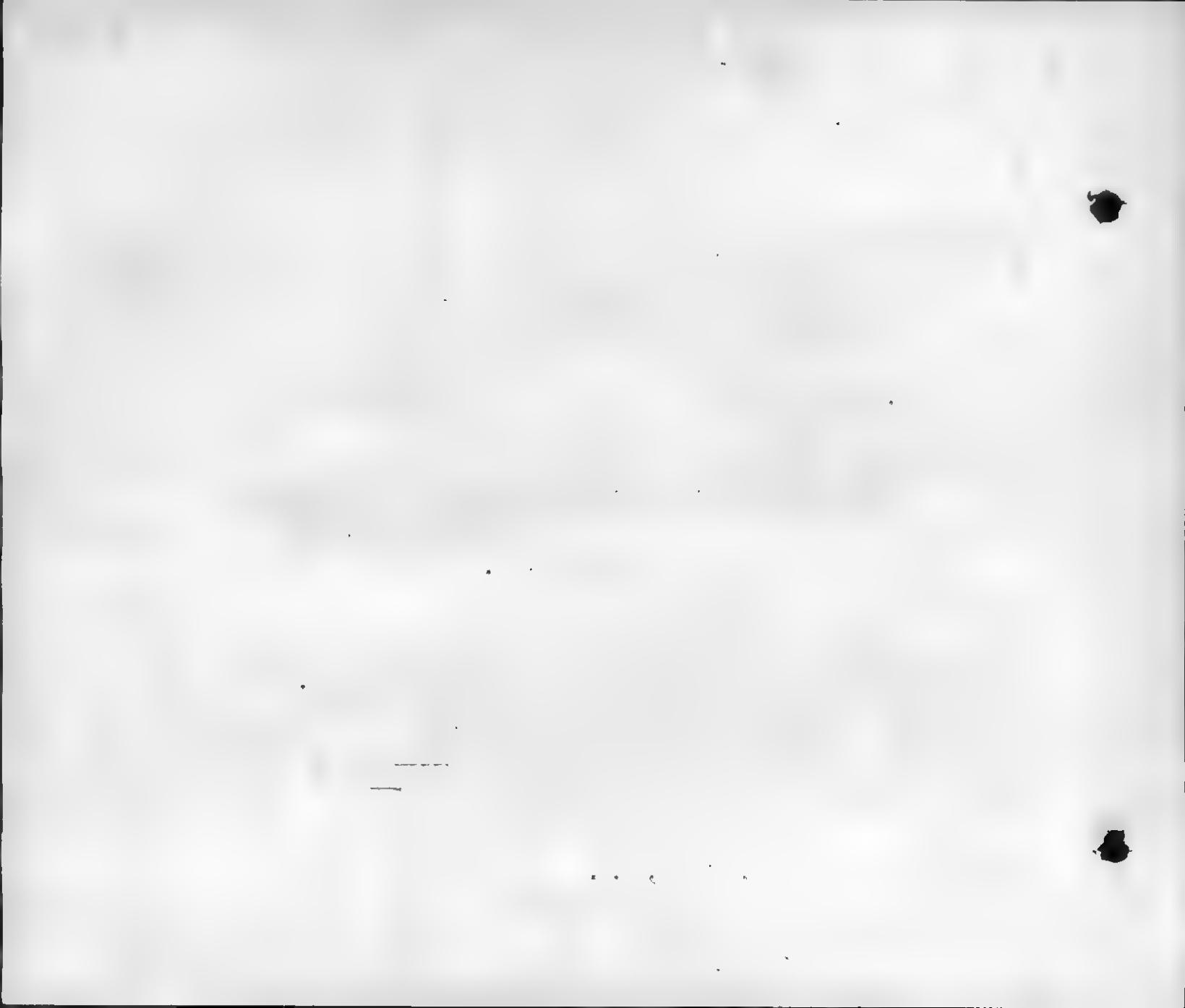
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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02632

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		Reg. Dist. No.	
Anne Arundel		MARYLAND		a. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY Mineral	
Gambrills				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RECORD ON A FARM YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	
MILDRED		ANN	JACKSON	Month March	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years from birthday)
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10/12/31	28 27
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
housewife				Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
B. Lewis Hill		Clara Mallory		USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Massive Aspiration of Blood due to Multiple Contusions of Face and Head due to Multiple Blunt Impacts to the Head, and Ligature Encirclement of Neck.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> 1/11 19 59 p m		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, off a bldg., etc.) Unknown	
				(City or town) Unknown (County) Unknown (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		Russell S. Fisher, M.D.		DATE SIGNED 3/24/59	
EXAMINER'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL	
Burial Mar. 26, 1959				22d. LOCATION (City, town, or county) Pendleton, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
Woodward Funeral Home		Laurin		24b. REG STAR'S SIGNATURE Arthur S. Fisher	
				DATE MAR 30 '59	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-troussal permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02633

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Anne Arundel

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE Virginia

b. COUNTY

Virginia

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Gambrills

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Mineral

e. IS RESIDENCE
ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Found

Month
March

Day
21

Year
1959

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

2/1/54

9. AGE (In years
last birthday)

5

10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Carroll Vernon Jackson, Jr.

14. MOTHER'S MAIDEN NAME

Mildred Ann Hill

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

[If yes, or unknown]

16. SOCIAL SECURITY NO.

17. INFORMANT

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Craniocerebral Injury with Fracture of Skull,

INDEXED Left Subdural Hematoma and Left Frontal Contusions

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b) INDEXED with Aspiration of Blood due to Multiple Blunt

Impacts to the Head.

(c)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

Assaulted by unidentified assailant.

20c. TIME OF INJURY

Month Day Year

Hour

1/11 1959

20d. INJURY OCCURRED

While
of work Not while
of work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Unknown

Unknown

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

Russell S. Fisher

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

3/24/59

EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

Burial

Mar. 26, 1959

Jackson Family Cemetery, Pendleton, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Woodward Funeral Home
Laurita rd.

MAR 30 '59

Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PNA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used on a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and keep a copy within 72 hours after death.

VS. A15ME
SM 2/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

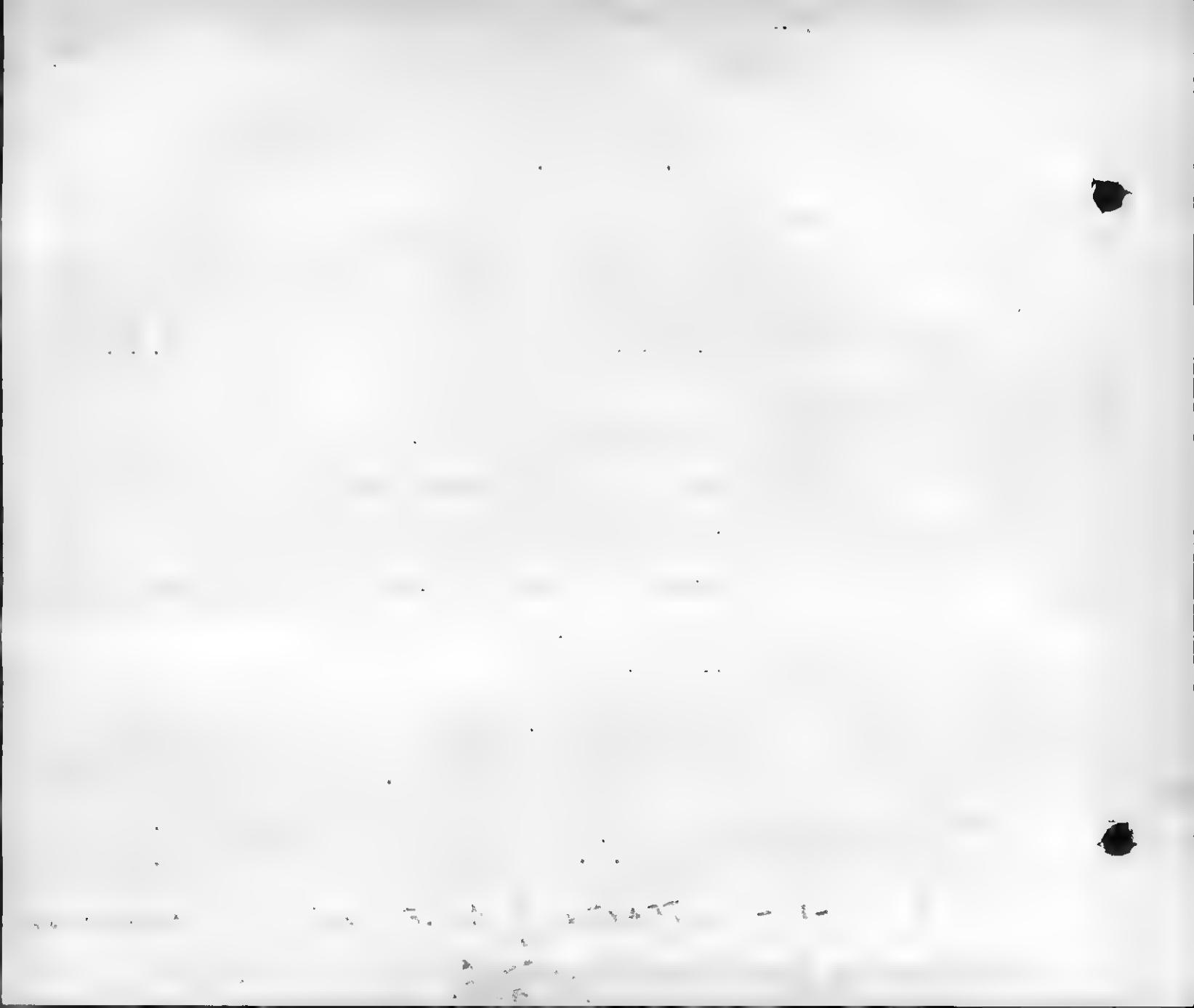
2662

CERTIFICATE OF DEATH

112634

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 9yr. 6mo 17days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks, MARYLAND		d. STREET ADDRESS ?		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Thomas	Middle	Last Jackson	4. DATE OF DEATH 3 9 19 59	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/18/95	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY: U.S.A.		
13. FATHER'S NAME Victory Jackson		14. MOTHER'S MAIDEN NAME Susan Venex						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Hospital Records	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Dehydration, Inanition and Toxemia		INTERVAL BETWEEN ONSET AND DEATH						
332 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO Decubitus Ulcers								
(c) DUE TO Cerebral Thrombosis with Right-Handed Hemiplegia-Old								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) COPD Hypertensive Cardiovascular Disease CNS Syphilis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----						
20c. TIME OF INJURY Hour a. ----- p. m. 19	Month -----	Day -----	Year -----	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) -----	(County) -----	(State) -----
21. I certify that I attended the deceased from 8/22 , 1949, to 3/9 , 1959, that I last saw the deceased alive on 3/9 , 1959, and that death occurred at 10:30P.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 3/10/59								
ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i>	M.D. Crownsville State Hospital, Md. 3/10/59							
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.	Crownsville State Hospital, Md. 3/10/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-12-59	22c. NAME OF CEMETERY OR CREMATORIAL STEAVENSON A.M.E. SPARKS, MARYLAND		22d. LOCATION (City, town, or county) (State) 914				
23. FUNERAL DIRECTOR'S SIGNATURE William Jackson	ADDRESS 14th and PENNA. AV.	24a. REC'D BY REGISTRAR MAR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas				



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

82635

2663

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY AA		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena (Rural)		c. LENGTH OF STAY IN 1b 15 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		d. STREET ADDRESS Mountain Road, RFD 3, Box 6		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mountain Road, RFD 3, Box 6						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Ahrie		First	Middle G.	Last Jenkins	4. DATE OF DEATH March	Month March	Day 13	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1875		9. AGE (In years last birthday) 83 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME Daniel L. Stone		14. MOTHER'S MAIDEN NAME . Elizabeth						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Elizabeth Hahn, same as 2		Address		
no		none						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42 d.1		INTERVAL BETWEEN ONSET AND DEATH Arterio- Sclerotic Cardio-Vascular Disease						
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 1951, to 21/3/59, 19, that I last saw the deceased alive on 31/7/59, 19, and that death occurred at M, from the causes and on the date stated above. ACTUAL SIGNATURE Gustave H. Faubert, M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 3/16/69						
PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.		5 First Ave. SE, Glen Burnie, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/17/59		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Baltimore 24, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE James E. Kirkley		ADDRESS Hopping and Kirkley, Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE MAR 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Faure		

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar or be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 2 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2664 CERTIFICATE OF DEATH

Reg. Dist. No. 02636

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town HANOVER		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridge Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hanover	
3. NAME OF DECEASED (Type or print) First Annie Middle Frances Last Johnson		d. STREET ADDRESS Ridge Road	
4. DATE OF DEATH March 16 1959		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1893
		9. AGE (in years last birthday) 66 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) never worked		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William George Johnson		14. MOTHER'S MAIDEN NAME Annie Maria Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT	
		none Edward N. Jones, Ridge Road, Hanover, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <input checked="" type="checkbox"/> DUE TO DIABETIC COMA Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO DIABETES MELLITUS (c) DUE TO GENERALIZED ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MYOCARDIAL DISEASE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) ADDRESS (Street, city or town, state)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 1958, to <u>3 March</u> , 1959, that I last saw the deceased alive on <u>3 March</u> , 1959, and that death occurred at <u>9A</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>George C. Gleason</u> M.D. 5608 Main St. Elmhurst 24, 1959 PHYSICIAN'S NAME (Type)		DATE SIGNED ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-18-59	
22c. NAME OF CEMETERY OR CREMATORIAL Elkridge Methodist Cemetery		22d. LOCATION (City, town, or county) Elkridge, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS	
		24a. REC'D BY REGISTRAR MAR 18 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2665

CERTIFICATE OF DEATH

Reg. Dist. No. 0263?

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 6yr.10mo.4days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		d. STREET ADDRESS ?		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Katie	Middle	last Jordan	4. DATE OF DEATH Month 3	Day 23	Year 19 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1890		9. AGE (In years last 68 day) yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Robert Moore				14. MOTHER'S MAIDEN NAME Kitty Shorter				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] Unknown		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) AHCVD DUE TO (c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH [If either, notify medical examiner]		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.] -----						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) -----		20f. (City or town) ----- (County) ----- (State) -----		
21. I certify that I attended the deceased from 5/19 , 1952, to 3/23 , 1959, that I last saw the deceased alive on 3/23 , 1959, and that death occurred at ----- , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Hildegard Heard Reissman</i> M.D. Crownsville State Hospital, Md. DATE SIGNED 3/23/59								
PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D. Crownsville State Hospital, Md. 3/23/59								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2. 6 Mar. 1959		22c. NAME OF CEMETERY OR CREMATORIUM St. Luke's		22d. LOCATION (City, town, or county) Reisterstown (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons - Reisterstown, Md.				24a. REC'D BY REGISTRAR MAR 26 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2617

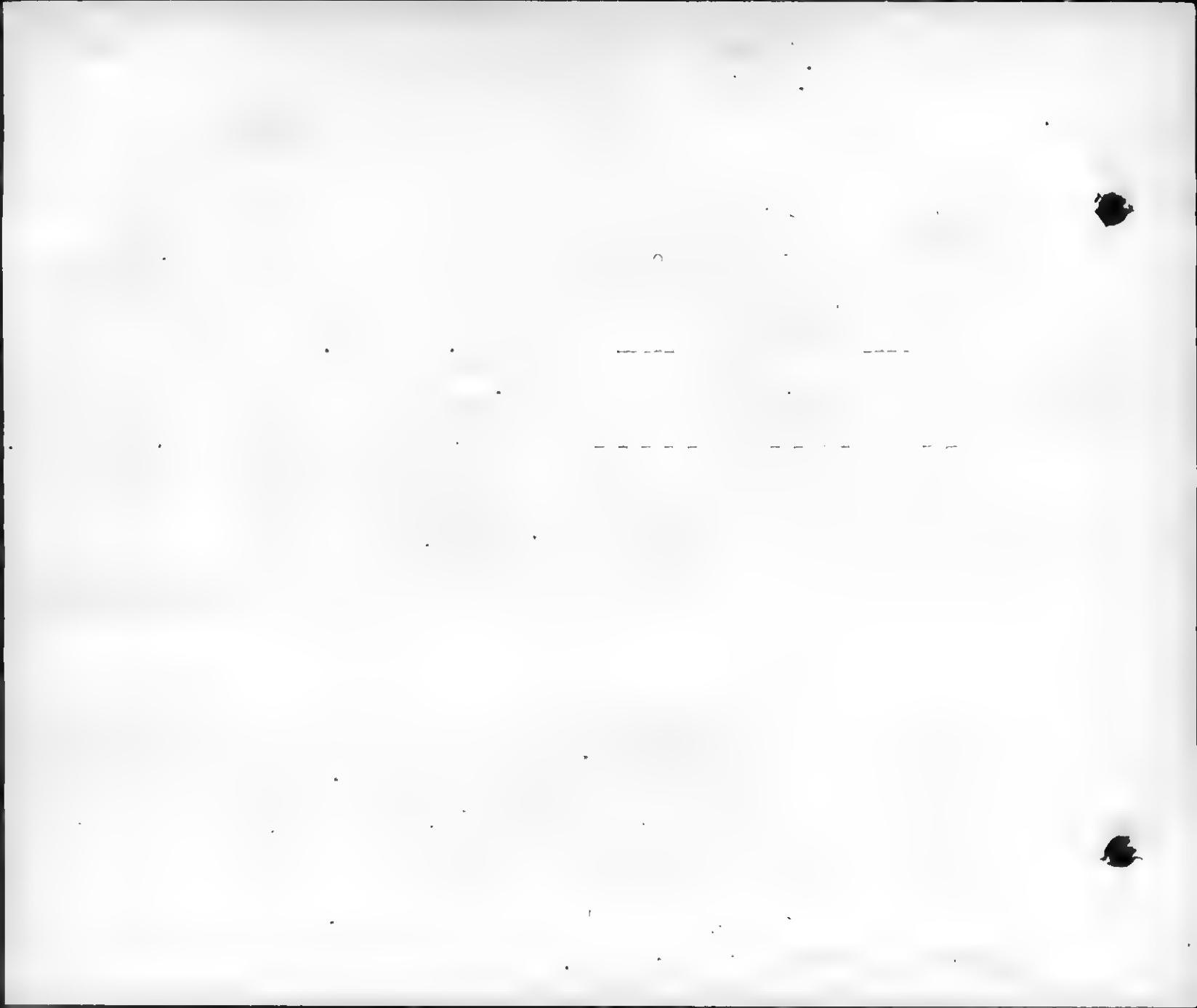
CERTIFICATE OF DEATH

Reg. Dist. No. 112635

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be revised by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		b. COUNTY Anne Arundel						
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Anne Arundel General Hospital		d. STREET ADDRESS 20 Jefferson Place						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)	First Irene	Middle Lorraine	Last Katriss					
4. DATE OF DEATH	Month March	Month 27	Day Year 1959					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1959					
9. AGE (In years lost birthday) yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleswoman	11. KIND OF BUSINESS OR INDUSTRY Saleswoman	12. BIRTHPLACE (State or foreign country) Annapolis, Md.					
13. FATHER'S NAME William John Katris	14. MOTHER'S MAIDEN NAME Margaret W. Dennison							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----	16. SOCIAL SECURITY NO. -----	INFORMANT Mother	Address 20 Jefferson Place, Annapolis, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>a physician</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause last</u> (b) <i>failure to intubate aspirations</i> DUE TO (c) <i>possible CNS depression (unintended)</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) Annapolis	(County) Anne Arundel	(State) Md.
21. I certify that I attended the deceased from <u>3/27</u> , 19 <u>59</u> to <u>3/27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/27</u> , 19 <u>59</u> , and that death occurred at <u>12:25 P.M.</u> <i>the causes and on the date stated above.</i>				ADDRESS (Street, city or town, state) <i>Annapolis, Md.</i>			DATE SIGNED <i>3/28/59</i>	
ACTUAL SIGNATURE <i>S. Borsuck</i>	M.D. <i>James Janes</i>							
PHYSICIAN'S NAME (Type) <i>S. BORSSUCK</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 28, 1959	22c. NAME OF CEMETERY OR CEMATORIAL St. Mary's Cemetery	22d. LOCATION (City, town, or county) Annapolis		(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Krause</i>	ADDRESS <i>20 Jefferson Place, Annapolis, Md.</i>	24a. REC'D BY REGISTRAR DATE MAR 31 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
2618

D2639

Reg. Dist. No

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with farm P.M.s. Page 5 may be retained for your files.

Funeral Director: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
3M 9/55

1. PLACE OF DEATH a. COUNTY <i>Annapolis</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>1/2 General</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Annapolis</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Thomas E. Keen</i>		4. DATE OF DEATH <i>Nov 11 1893</i>	Month <i>3</i> Day <i>21</i> Year <i>1959</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 11 1893</i>			
9. AGE (in years last birthday) <i>66</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Construction Engineer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Engineer</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	13. FATHER'S NAME <i>Thomas S. Keen</i>					
14. MOTHER'S MAIDEN NAME <i>Margaret Reese</i>	Address <i>Edna S. Keen (2)</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>						
16. SOCIAL SECURITY NO. <i>123-45-6789</i>						
17. INFORMANT <i>Edna S. Keen</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>434.4</i> DUE TO <i>Cardiac Disease</i>						
Conditions, if any, which gave rise to immediate cause (b) <i>None</i>						
DUE TO (c) <i>None</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>None</i>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>				
20c. TIME OF INJURY Hour d. m. p. m.	Month, Day, Year <i>Nov 19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> <i>E. L. Inman</i>						
ACTUAL SIGNATURE <i>E. L. Inman</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <i>3/21/59</i>		
EXAMINER'S NAME (Type) <i>E. L. Inman</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-24-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>London Park Cemetery</i>	22d. LOCATION (City, town, or county) <i>Baltimore</i>	(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md</i>	24a. REC'D BY REGISTRAR <i>DAH MAR 24 '59</i>	24b. REGISTRAR'S SIGNATURE <i>John M. Taylor Sons</i>		



02640

Reg. Dist. No.

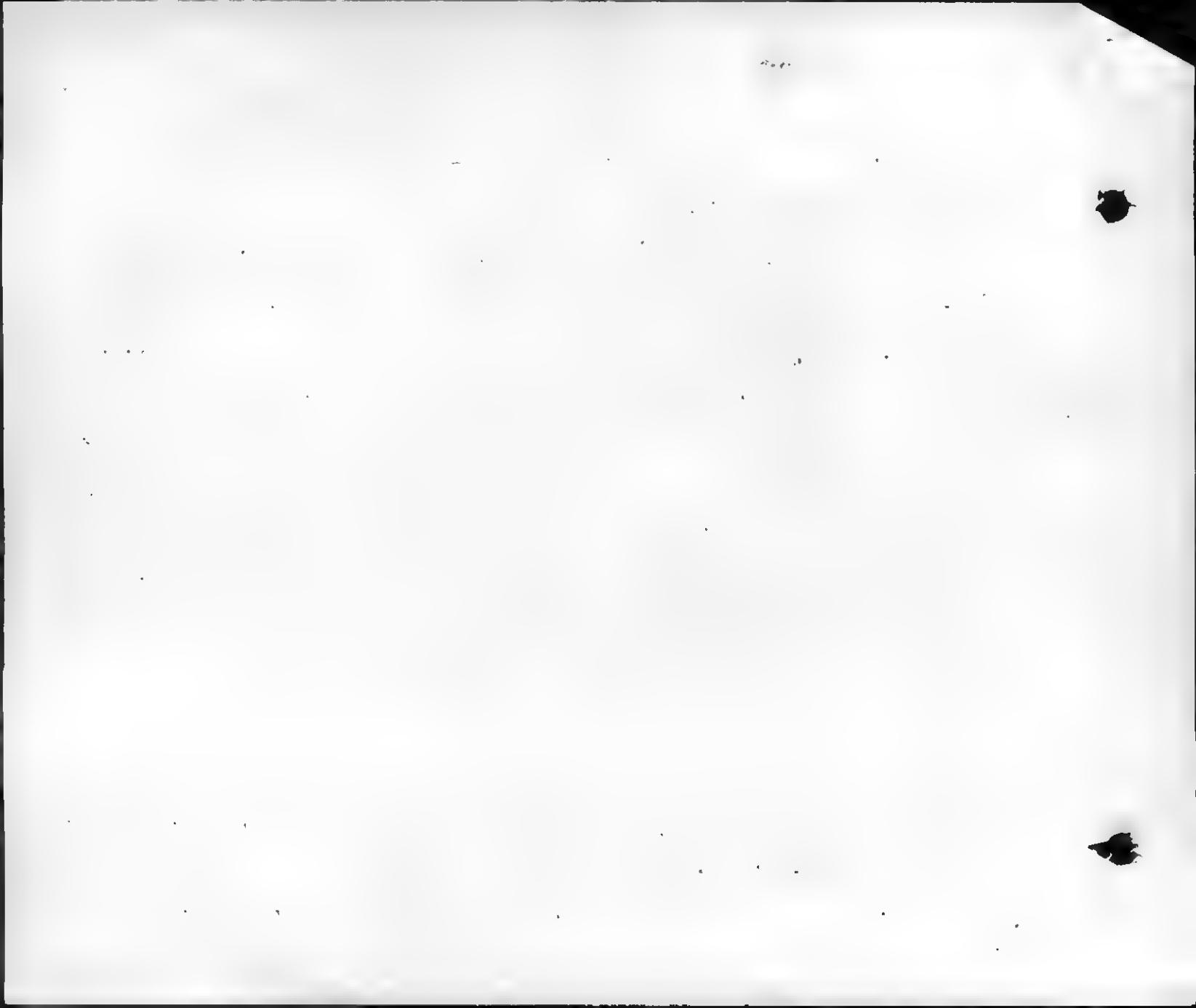
2619

CERTIFICATE OF DEATH

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **May** be retained by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, **the funeral director** should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Edgewater,		d. STREET ADDRESS /	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF Frank (Type or print)		First A.	Middle 	Last KENNEDY	4. DATE OF DEATH March	Month 27	Day 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/14/94	9. AGE (In years lost birthday) 64 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) News Correspondent		10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Stewart Kennedy		14. MOTHER'S MAIDEN NAME Cora Belle Hiteshew					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 57846-2892		INFORMANT Mary Anne Kennedy - Edgewater, Maryland	Address 		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177 X DUE TO Pulmonary edema INTERVAL BETWEEN ONSET AND DEATH 1 mo Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastases (c) Carcinoma of Prostate 2 1/2 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/8 , 19 56 , to 3/26 , 19 59 , that I last saw the deceased alive on 3/26 , 19 59 , and that death occurred at 3:10 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Edwin Davis, Jr. ADDRESS (Street, city or town, state) 98 Cathedral St, Annapolis, Md 3221939							
22a. CERIAL, CREMATION, REMOVALS (Specify) Cremation		22b. DATE THEREOF 3/28/59		22c. NAME OF CEMETERY OR CRYPTORY Edwin Davis, Jr.		22d. LOCATION (City, town, or county) Ward (State) (MD)	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Davis, Jr.		ADDRESS 1011 18th St. N.E.		24a. REC'D. BY REGISTRAR MAR 30 '59 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02641

2666

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL

Towson Md

c. LENGTH OF STAY IN 1b

1 week

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Schen's Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Baltimore City, Md

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore City, Md

d. STREET ADDRESS

1202 26th St

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)First: Irene
Middle: J.

Last: Kilby

4. DATE
OF
DEATH

Month: 3

Day: 14

Year: 1959

5. SEX

F.

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

August 12-1900

9. AGE (In years
last birthday)
yrs.

58

10. IF UNDER 1 YEAR
Months: 0 Days: 011. IF UNDER 24 HRS
Hours: 0 Min: 010a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

S. W. 22

10b. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert W. Kilby

14. MOTHER'S MAIDEN NAME

Alice Whittle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Walter S. Kilby Uncle, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Aspiration Pneumonia

INTERVAL BETWEEN
ONSET AND DEATHConditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

3 Pneumonia

(c)

Multiple S. I. Pneumonia

1/1/59

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. — 19 p. m.20d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 2-62, 1959, to 3-18, 1959, that I last saw the deceased
alive on 2-15, 1959, and that death occurred at 8:20 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Felicie Kilby

PHYSICIAN'S
NAME (Type)

Felicie Kilby

3-18-59

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

3-21-59

22c. NAME OF CEMETERY OR CREMATORI

Glen Haven Memorial

22d. LOCATION (City, town, or county)

Glen Burnie Md

23. FUNERAL DIRECTOR'S SIGNATURE

Julia M. Taylor Son Annapolis Md

ADDRESS

24a. REC'D BY REGISTRAR

DATE MAR 23 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page _____ may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2667

CERTIFICATE OF DEATH

Reg. Dist. No. 02642

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort G. G. Meade, Md</u>		c. LENGTH OF STAY IN 1b <u>10 Mo's</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		d. STREET ADDRESS <u>1815 Maltravers Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>US Army Hospital, Bldg 2101-1)</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Henry</u>		First	Middle	Last	4. DATE OF DEATH <u>Krauss</u>	Month	Day	Year	
5. SEX <u>M</u>		6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>29 Nov 1894</u>	9. AGE (in years from last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Ignaty Krauss</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW I 107052213</u>		17. INFORMANT <u>(Son) Melvin H. Krauss</u>		Address <u>Glen Burnie, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Cerebral Emboli</u>						INTERVAL BETWEEN ONSET AND DEATH <u>14 Days</u>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <u>Myocardial Infarction</u>						18 Days			
DUE TO (c) <u>Arteriosclerotic Heart Disease</u>						6 Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bleeding Duodenal Ulcer</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Glen Burnie</u>		(County)	(State)
21. I certify that I attended the deceased from <u>1 February, 1958</u> , to <u>28 March, 1959</u> , that I last saw the deceased alive on <u>28 March, 1959</u> , and that death occurred at <u>118 M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Allan H. Toffler</u>						ADDRESS (Street, city or town, state) <u>New York, N.Y.</u>			
PHYSICIAN'S NAME (Type) <u>Allan H. Toffler, Capt MC</u>						DATE SIGNED <u>11. S. Henry Hops, F. F. Meade, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>3/28/59</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>United Hebrew</u>		22d. LOCATION (City, town or county) <u>New York, N.Y.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sal Benson & Sons</u>		ADDRESS <u>1124 W. North</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krauss</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

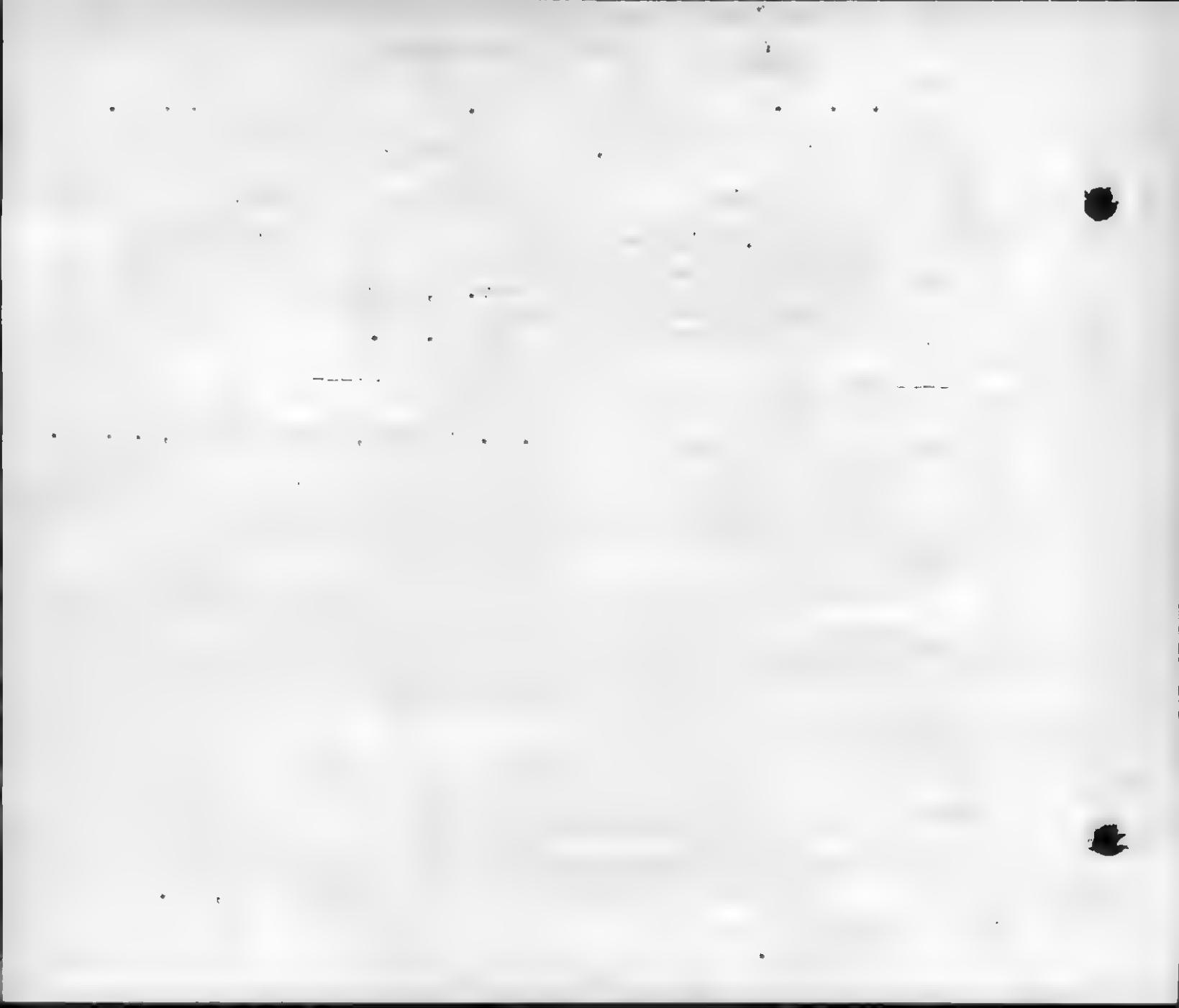
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10 M I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2668 CERTIFICATE OF DEATH 02643

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A. A. Co.		1b. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admis'sn) a. STATE Md.		b. COUNTY A.A. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Orchard Beach		c. LENGTH OF STAY IN 1b 5 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Orchard Beach		d. STREET ADDRESS 1208 Beach Promenade			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1208 Beach Promenade				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mamie E. Kritwize		First Middle		4. DATE OF DEATH March 31/59		Month March	Day 31	Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1890	9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Schrader				14. MOTHER'S MAIDEN NAME Elizabeth					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Geo. F. Kritwize, Orchard Beach, A.A. Co. Md		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Acute coronary thrombosis Arterosclerotic Cardio-vascular disease		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Baltimore	(State) Md.
21. I certify that I attended the deceased from Jan. 20, 1953, to March 31, 1959, that I last saw the deceased alive on March 29, 1959, and that death occurred at 6:45 A.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) RFD #8 Box 442 Pasadena, Md.		DATE SIGNED Mar. 31, 1959	
ACTUAL SIGNATURE Randall M. McLaughlin, M.D.									
PHYSICIAN'S NAME (Type) Randall M. McLaughlin									
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF April 3/59		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park		22d. LOCATION (City, town, or county) Baltimore		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fitzke Funeral Directors 4101 Edmondson Ave.		ADDRESS				24a. REC'D BY REGISTRAR APR 1 '59		24b. REGISTRAR'S SIGNATURE Charles S. Knecht	



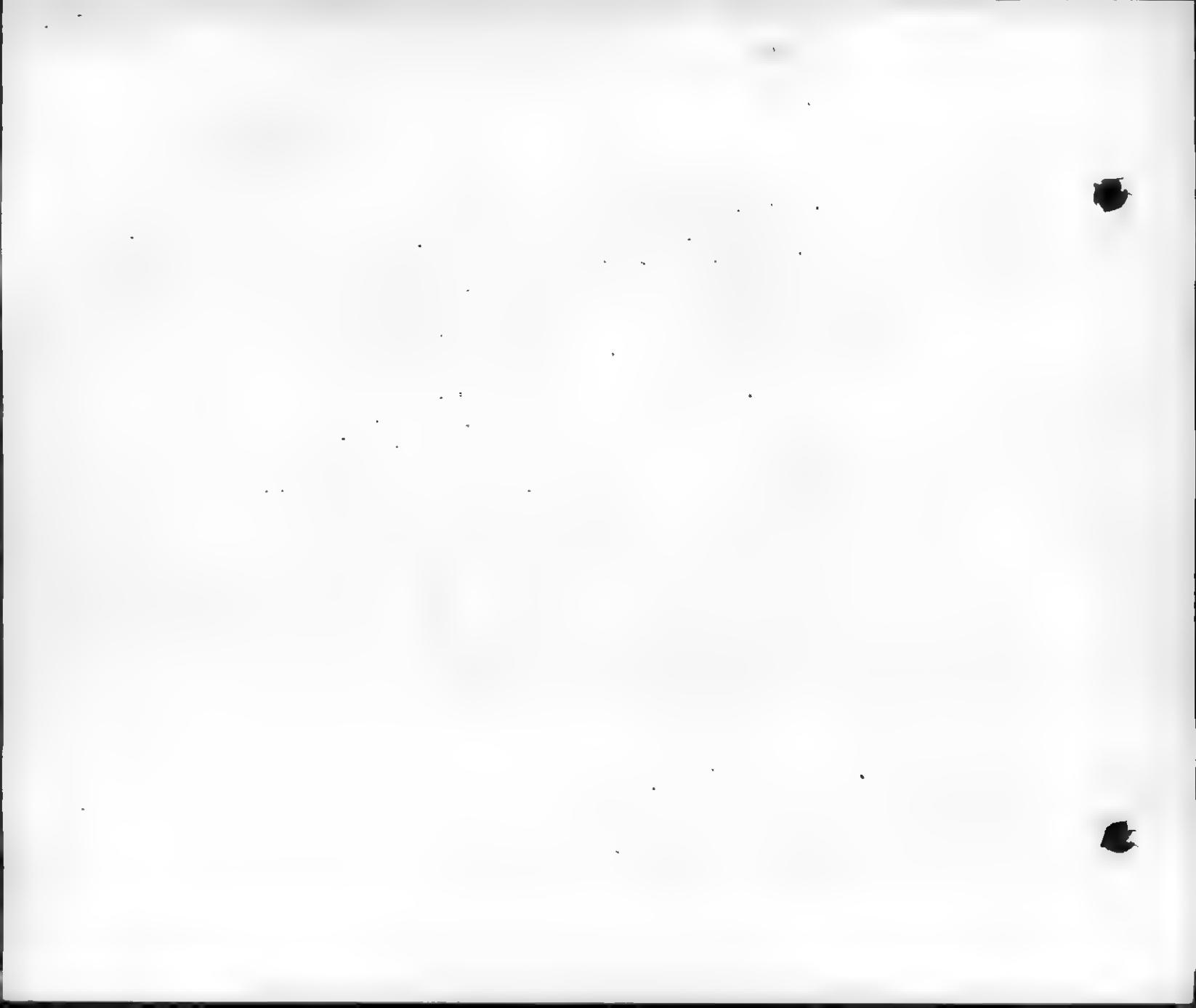
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2620 CERTIFICATE OF DEATH

Reg. Dist. No. **02644**

1. PLACE OF DEATH a. COUNTY A. A. Co		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN 1b RURAL and give nearest town Woodland Beach									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) JOSEPH ISRAEL LASALLE	First	Middle	Last								
4. DATE OF DEATH	Month 3	Day 15	Year 1955								
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/27/38								
9. AGE (In years last birthday) 81	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0 Min. 0								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Health Inspector	10b. KIND OF BUSINESS OR INDUSTRY District of Columbia	11. BIRTHPLACE (State or foreign country) Carthage N.Y	12. CITIZEN OF WHAT COUNTRY?								
13. FATHER'S NAME John Baptiste La Salle	14. MOTHER'S MAIDEN NAME Unknown										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO	16. SOCIAL SECURITY NO 579-36-3933	INFORMANT Richard Michaelis	Address RT 3, Box 218, Edgewater Md.								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Part I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____ DUE TO (c) _____ Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
			INTERVAL BETWEEN ONSET AND DEATH 2 hr.								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20c. TIME OF INJURY Hour a. m. 19	Month 3	Day 15	Year 1955	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Bladensburg	(County) Prince George's Co.	(State) Md.			
21. I certify that I attended the deceased from 3/15/55 to 3/15/55 , that I last saw the deceased alive on 3/14/55 , and that death occurred at 12:45 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 121 CATHEDRAL ST			DATE SIGNED 5/17/55				
ACTUAL SIGNATURE <i>Richard Michaelis</i>	PHYSICIAN'S NAME (Type) RICHARD N. PEELER			22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 3/18/59	22c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln	22d. LOCATION (City, town, or county) Bladensburg	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardisty</i>				ADDRESS <i>Halesville</i>	24a. REC'D BY REGISTRAR DATE MAR 23 '59	24b. REGISTRAR'S SIGNATURE <i>Orville S. Trahan</i>					



81
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMJ. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2663 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02645

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived - if institution, Residence before admission) o STATE MD. b COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Millersville.		c. LENGTH OF STAY IN 1b 1 year	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel Home			
e. IS RELICED ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
Alma		J.	Lewis
4. DATE OF DEATH	Month	Day	Year
Mar. 16, 1957			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 15 1876
Female	White		9. AGE (In years less birthday) 82 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Miss.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Bilb.			
14. MOTHER'S MAIDEN NAME Frances Hines			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO 100-00-0000	17. INFORMANT Mrs. B.M. Gallus
		Address 413A 11th St. Bldg. Apt. 3A Sweden	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO 331X Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture hip			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fall & fracture hip.	
20c. TIME OF INJURY Hour e. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Albco	(County) Albco	(State) W.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> E. P. Burkhardt F. L. Burkhardt			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 3/16/57
22a. BURIAL, CREMATION REMOVAL (Specify) Exhumed Mar 18, 1957	22b. DATE THEREOF Mar 18, 1957	22c. NAME OF CEMETERY OR CREMATORIUM R. H. Crem.	22d. LOCATION (City, town, or county) Washington, D. C. (State)
23. FUNERAL DIRECTOR'S SIGNATURE John L. Burkhardt		24a. REC'D BY REGISTRAR MAR 20 '59	24b. REGISTRAR'S SIGNATURE
ADDRESS 1401 14th St. N.W. Washington, D. C. 20004		DATE MAR 20 '59	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2670

CERTIFICATE OF DEATH

Reg. Dist. No.

02646

1. PLACE OF DEATH a. COUNTY		ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		MD.		b. COUNTY		ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PASADENA		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PASADENA		d. STREET ADDRESS		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RTE. 1, BOX 305, FOREST GLEN		e. STREET ADDRESS RTE. 1, Box 305, FOREST GLEN		f. DATE OF DEATH		Month MAR.		Day 26		Year 1959	
3. NAME OF DECEASED (Type or print) RUDOLPH		First	Middle	4. DATE OF DEATH	Month	Day	Year				
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21, 1895	9. AGE (In years last birthday) 63 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? PASADENA, MD.	
13. FATHER'S NAME GEORGE H. MACK		14. MOTHER'S MAIDEN NAME AUGUSTA WITTE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT LILLIAN K. MACK		Address PASADENA, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) (c)		Carcinomatosis		INTERVAL BETWEEN ONSET AND DEATH 5 months							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from <u>October 23, 1958</u> , to <u>March 26, 1959</u> , that I last saw the deceased alive on <u>March 24, 1959</u> , and that death occurred at <u>4:05 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED							
ACTUAL SIGNATURE R. M. McLaughlin		M.D. <u>REDS Box 442 Pasadena, Md. March 26, 1959</u>									
PHYSICIAN'S NAME (Type) R. M. McLaughlin											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-30-59		22c. NAME OF CEMETERY OR COLUMBIARIUM OAK LAWN		22d. LOCATION (City, town, or county) BALTO. CO.		(State) MD.			
23. FUNERAL DIRECTOR'S SIGNATURE C. F. Hoffmann		ADDRESS 3218 HUDSON ST.		24a. REC'D BY REGISTRAR DATE MAR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Keene					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG239 3-4-3 et

2671

CERTIFICATE OF DEATH

Reg. Dist. No.

02647

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Anne Arundel</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Roxbury</i>		c. LENGTH OF STAY IN 1b <i>3 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Roxbury</i>		d. STREET ADDRESS <i>Race Road</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Race Road</i>				d. STREET ADDRESS <i>Race Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Samuel</i>		First <i>S</i>	Middle <i>J</i>	Last <i>Magee</i>	4. DATE OF DEATH <i>March 2</i>	Month <i>March</i>	Day <i>2</i>	Year <i>1959</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 19, 1871</i>	9. AGE (in years last birthday) <i>87</i>	10. IF UNDER 1 YEAR Months <i>11</i>	11. IF UNDER 24 HRS. Hours <i>11</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinery</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>Unk.</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT <i>Irene Keenan</i>		Address <i>Race Road</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4</i>		DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.</i>		VENTRICULAR FIBRILLATION		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>		
(b) DUE TO <i>Arteriosclerotic Cardiovascular Disease —</i>		(c) <i>Generalized Arteriosclerosis</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>2-13, 1959</i> to <i>2-1, 1959</i> , that I last saw the deceased alive on <i>2-1-59</i> , and that death occurred at <i>12 PM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>RFD #1 Jessup</i>		DATE SIGNED <i>3-1-59</i>		
ACTUAL SIGNATURE <i>Irene Keenan</i>								
PHYSICIAN'S NAME (Type) <i>Jose M. Yosuico, M.D.</i>		RFD # 1, Jessup, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/4/59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Francis Cemetery</i>		22d. LOCATION (City, town, or county) <i>Pawtucket, R. I.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping and Kirkley</i>		ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D. BY REGISTRAR <i>MAR 4 1959</i>		24b. REGISTRAR'S SIGNATURE <i>John J. Quinn</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.



Page 4
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

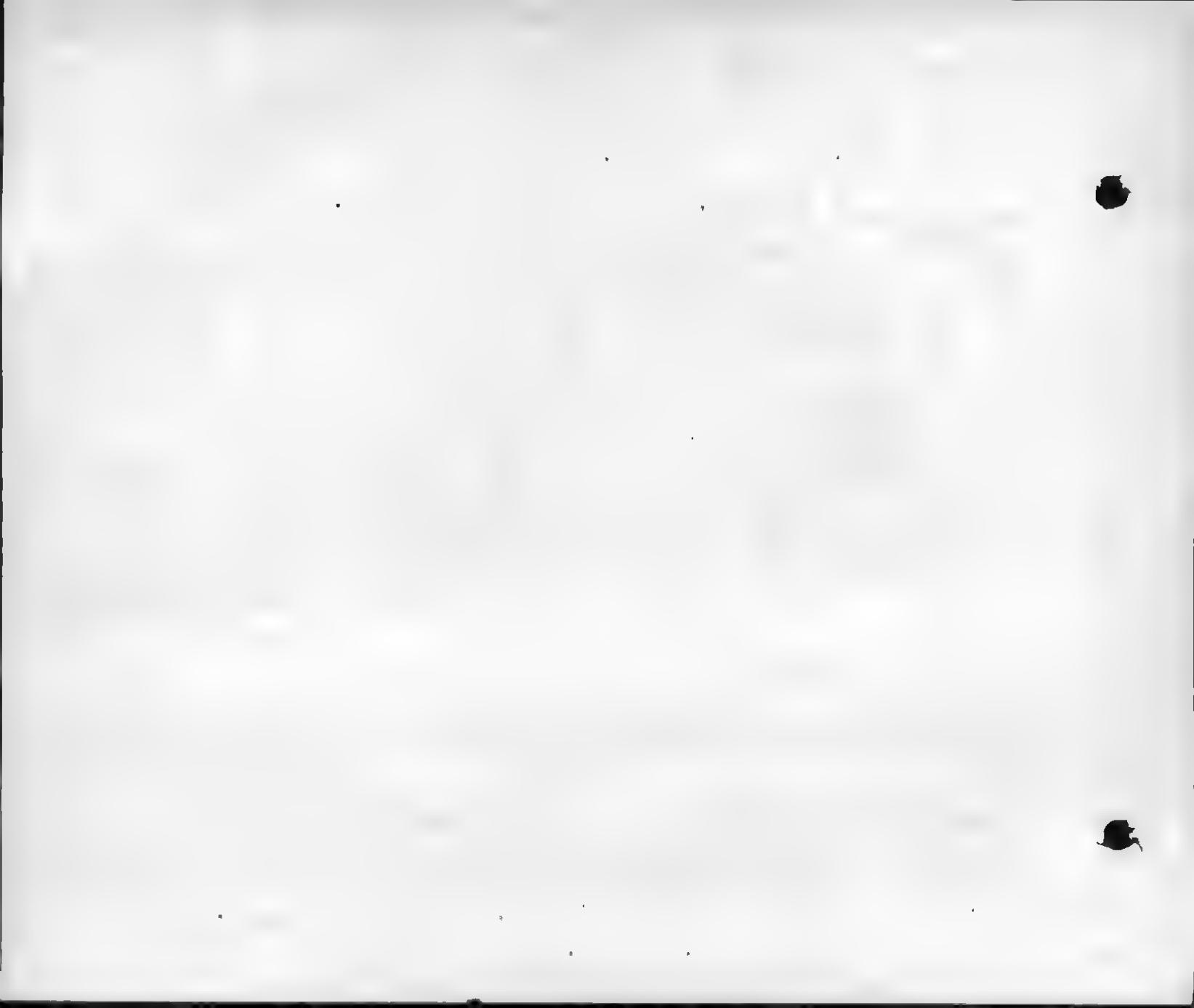
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02649

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY AA		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn		c. LENGTH OF STAY IN 1b Yrs. /	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 Church St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn	
f. STREET ADDRESS 106 Church St.		d. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George (Gaetano Barboni)		First Middle Last Martin	4. DATE OF DEATH 31
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-1-1890
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef		10b. KIND OF BUSINESS OR INDUSTRY Hotel Business	
11. BIRTHPLACE (State or foreign country) Switzerland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO WV 1 578 09 2853	17. INFORMANT Family
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Pulmonary Carcinomatosis c metastasis PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Nov - 58 to March 59			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov , 1958, to 14 March , 1959, that I last saw the deceased alive on 14 March , 1959, and that death occurred at 9:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Andrew R. Sosnowski 14 March 59			
ACTUAL SIGNATURE Andrew R. Sosnowski		PHYSICIAN'S NAME (Type) Andrew R. Sosnowski	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/10/59	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cem.
22d. LOCATION (City, town, or county) Brooklyn, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Fort Ave.		24a. REC'D BY REGISTRAR DATE MAR 17 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Thrane



1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

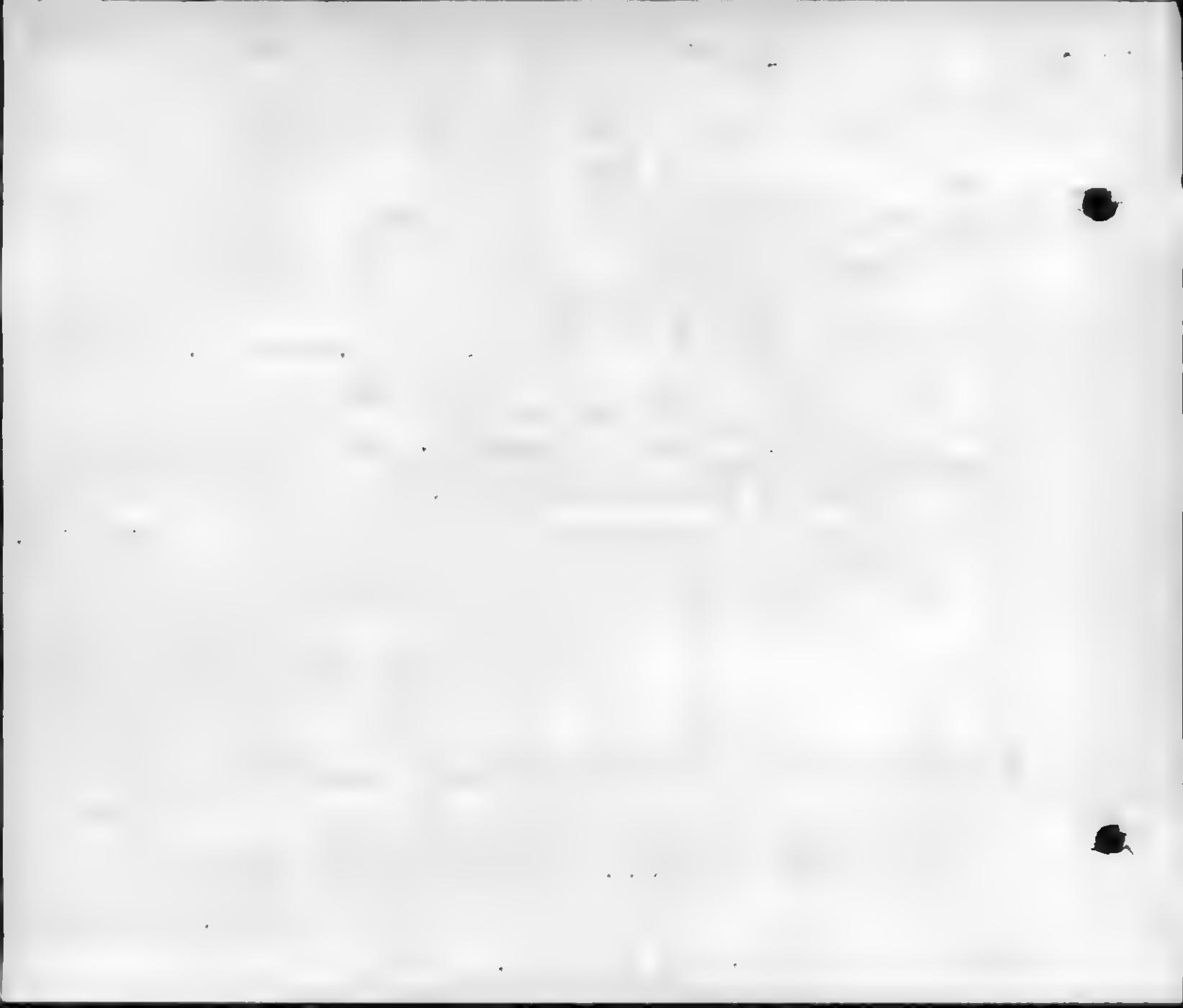
02650

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "Pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health; or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Same		b. COUNTY Same	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) X		d. STREET ADDRESS Same	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 2 Box 96, Sansers Park				e. IS RES'D OF C.F. ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Marlene Elizabeth McAvoy		First	Middle	4. DATE OF DEATH March 5th 1959	Month	Day	Year 19
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9/27/58	9. AGE (in years last birthday) 5	10. IF UNDER 1 YEAR Months 5	11. IF UNDER 24 HRS. Days 6	12. HOURS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Agnes Hosp. Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert McAvoy		14. MOTHER'S MAIDEN NAME Barbara Holthouse		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yea, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr and Mrs. Robert McAvoy (parents)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary infection.		19. INTERVAL BETWEEN ONSET AND DEATH Sudden		20. ADDRESS	
21. DUE TO Malnutrition		22. DUE TO Malnutrition		23. DUE TO Malnutrition		24. DUE TO Malnutrition	
25. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		26. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
27. MEDICAL CERTIFICATION ACTUAL SIGNATURE: <i>Gustave H. Faubert, M.D.</i>		28. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		29. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) 20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		30. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
31. DATE OF DEATH 3/7/59		32. PLACE OF DEATH (City, town, or county) Baltimore 25, Md.		33. (County) Baltimore		(State) Md.	
34. BURIAL Cremation REMOVAL (Specify) Burial		35. DATE THEREOF 3/7/59		36. NAME OF CEMETERY OR CREMATORIAL Gedan Hill		37. LOCATION (City, town, or county) 24a. REC'D BY REGISTRAR DATE Arthur S. Kraus MAR 9 '59	
38. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley, Glen Burnie, Md.		39. ADDRESS James D. Kirkley		40. REGISTRAR'S SIGNATURE Arthur S. Kraus			



1
Item 2: Med. Exam.
FOR STATE
HEALTH DEPT.
4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to a burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2675
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03887**

1. PLACE OF DEATH
a. COUNTY **Anne Arundel** MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Annapolis Junction**

c. LENGTH OF STAY IN TB

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **Middle Patuxent River nr. B&O RR Bridge**

2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a. STATE **Virginia** b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Richmond**

d. STREET ADDRESS **512 Light Street**

e. IS RELATIVE ON A FARM?
YES NO

3. NAME OF DECEASED (Type or print) **NATHANIEL** First **McCoy** Middle

4. DATE OF DEATH **March 15 1959**

5. SEX **Male** 6. COLOR OR RACE **Colored** 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH

9. AGE (In years last birthday) **43 yrs** 10. IF UNDER 1 YEAR
Months **0** Days **0** Hours **0** Min **0** 11. IF UNDER 24 HRS

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) **Yes** (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **902.8** INDEX
Cerebral contusions
INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) **Fractured skull**
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
Fall from bridge

20c. TIME OF INJURY Month, Day, Year
Hour **UNKNOWN** 19 20d. INJURY OCCURRED
White Nat white
at work of work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **Bridge** 20f. (City or town) **Annapolis Junction** (County) **Anne Ar.** (State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE **Charles S. Petty, M.D.** DATE SIGNED
EXAMINER'S NAME (Type) **Charles S. Petty, M.D.** M.D. CHIEF MEDICAL EXAMINER
ASSISTANT MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
DATE SIGNED **March 16/59**

22a. BURIAL Cremation REMOVAL (Specify) 22b. DATE THEREOF **4.27.59** 22c. NUMBER OF CASKET OR CASKETS **1** 22d. LOCATION (City, town, or county) **Baltimore, Md.** (State)

23. FUNERAL DIRECTOR'S SIGNATURE **Arthur & Sons** ADDRESS **1010 Light Street** 24a. REC'D BY REGISTRAR DATE **APR 28 '59** 24b. REGISTRAR'S SIGNATURE **Arthur & Sons**

VS. A155
SM 2/57



MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

Item 14, Film 0240, 3/15/59

2676

CERTIFICATE OF DEATH

Reg. Dist. No.

02651

1. PLACE OF DEATH a. COUNTY <i>A. A.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MAGO VISTA</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LEONARDTOWN</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>RIVER ROAD</i>		d. STREET ADDRESS <i>NUNS OAK</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>ADA</i>	Middle <i>M.</i>	Last <i>McCULLOUGH</i>
4. DATE OF DEATH	Month <i>MARCH</i>	Day <i>13</i>	Year <i>1959</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 23, 1875</i>
9. AGE (In years last birthday) <i>83 yrs</i>		10. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>	11. BIRTHPLACE (State or foreign country) <i>ENGLAND</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>FARMER</i>		14. MOTHER'S MAIDEN NAME <i>Not known</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>David McCullough - Mago Vista, Md.</i>	
17. INFORMANT <i>Francis I. Codd</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>443X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 MO.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b)		Congestive heart failure	
DUE TO (c)		Hypertensive cardio-vascular disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May</i> , 1957, to <i>Mar. 13, 1959</i> , that I last saw the deceased alive on <i>March 10</i> , 1959, and that death occurred at <i>4:30 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>P.O. Box 289 Severna Park, Md.</i>		DATE SIGNED <i>3-13-59</i>	
ACTUAL SIGNATURE <i>Francis I. Codd</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>FRANCIS I. CODD M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremated</i>		22b. DATE THEREOF <i>3-16-59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Cathedral</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Fowler Funeral Home - Catonsville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 19 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02652

Reg. Dist. No.

2677

1. PLACE OF DEATH
a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL
and give nearest town)

BAY RIDGE

c. LENGTH OF STAY IN TB

(and give nearest town)

(If not in hospital, give street address)

52 RIVER DRIVE

3. NAME OF
DECEASED
(Type or print)

DANIEL

First

Middle

Last

E. McELLIN

4. DATE
OF
DEATH

Month
3

Day
4

Year
1959

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

WIDOWED

DIVORCED

10-11-1879

9. AGE (In years
last birthday)

79 yrs.

10. IF UNDER 1 YEAR

Months

Days

11. IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

CONTRACTOR R.F.

10b. KIND OF BUSINESS OR INDUSTRY

PLASTER

11. BIRTHPLACE (State or foreign country)

IRELAND

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

"UNK"

14. MOTHER'S MAIDEN NAME

"UNK"

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

—

17. INFORMANT

LICTORIA McELLIN #2

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

890.0

DUE TO

Asphyxia due to coal gas

INTERVAL BETWEEN
ONSET AND DEATH

6 hrs

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

(furnace)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fell out of in room - defective furnace caused coal fumes.

20c. TIME OF INJURY
Month, Day, Year
Hour
a. m.
p. m.

20d. INJURY OCCURRED
While
at work Not while
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
Baltimore
(County)
Anne Arundel Md.
(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

S. Borsuck

M.D. CHIEF MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S
NAME (Type)

S. BORSSUCK

ASSISTANT MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER

8/15/59

22a. BURIAL, Cremation,
Removal (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

John M. Taylor & Sons

ADDRESS

1100 Mt. Olivet

24a. REC'D BY REGISTRAR

(State)

MAR 9 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Kline

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02653

2678 CERTIFICATE OF DEATH

Item 1 FilmG241 4-6-59 et

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDANT: The law requires that the death certificate be executed within 24 hours after death.

TO PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

The bottom copy may be retained by the hospital or attending physician.

VS AISC 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	GA Co Md	STATE	GA Co
CITY (If outside corporate limits, write RURAL OR and give nearest town)	RURAL	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN	Arnold	OR TOWN	Arnold GA Co Md
HOSPITAL OR INSTITUTION OR STREET ADDRESS	At home	STREET ADDRESS	Box 498 RT 2
3. NAME OF DECEASED (First) John J. McLaughlin (Middle) (Last)		4. DATE (Month) (Day) (Year)	
5. SEX Male		6. COLOR OR RACE White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married		8. DATE OF BIRTH Sept 5 1886	
10a. USUAL OCCUPATION (Give kind of work done during most working hrs, even if retired) Packer		9. AGE last birthday 72 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md	
13. FATHER'S NAME James McLaughlin		14. MOTHER'S MAIDEN NAME Mary Schumeth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 216-10-2654	
17. INFORMANT & ADDRESS Viola M. McLaughlin		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 527.1 IMMEDIATE CAUSE (A) VIRUS PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 24 HRS.	
ANTECEDENT CAUSE(S) DUE TO (B) PNEUMONIA, LARYNGITIS		17. HRS.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work		21e. INJURY OCCURRED While at work	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3-7, 1959, to 3-27, 1959, that I last saw the deceased alive on 3-27, 1959, and that death occurred at 5:00 P.M. from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF March 31 '59	
24. REC'D BY REGISTRAR DATE MAR 31 '59		REGISTRAR'S SIGNATURE Arthur S. Kraus	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		Baptist Church, Glen Burnie Md	



FOR STATE
HEALTH DEPT.MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02654

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY D. A. CO.		2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) a. STATE MD b. COUNTY MD CO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Doll Anne Arundel General		d. STREET ADDRESS Jacobsville md	
3. NAME OF DECEASED (Type or print) MARY		First MIDDLE Last MCWILLIAMS	4. DATE OF DEATH -3 4 1959
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) md		9. AGE (In years last birthday) 74 yrs	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. IF UNDER 1 YEAR Months Days Hours Min.	
14. FATHER'S NAME George Carberry		15. MOTHER'S MAIDEN NAME James McWilliams Jacobsville md	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		17. INFORMANT James McWilliams Jacobsville md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c)		19. ADDRESS INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. Lombard		DATE SIGNED 3-4-59.	
EXAMINER'S NAME (Type) E. Lombard		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 3-9-59	
22c. NAME OF CEMETERY OR CREMATORIAL St Peters		22d. LOCATION (City, town, or county) Jacobs	
23. FUNERAL DIRECTOR'S SIGNATURE Geo S. Nelson		24a. REC'D BY REGISTRAR DATE MAR 6 '59	
ADDRESS 1348 n. Calhoun st		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2680

CERTIFICATE OF DEATH

Reg. Dist. No.

02655

1. PLACE OF DEATH a. COUNTY H. A.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pasadena		c. LENGTH OF STAY IN 1b 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6 Meadow Rd.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena	
f. STREET ADDRESS 6 Meadow Rd.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine J. Meyers		First Catherine	Middle J.
4. DATE OF DEATH 3-26-59		Month 3	Day 26
5. SEX F		6. COLOR OR RACE CU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1-2-20		9. AGE (In years last birthday) 39 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cater. Mage.		10b. KIND OF BUSINESS OR INDUSTRY Pasadenas Sel.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? 12. CITIZEN OF WHAT COUNTRY? Md.	
13. FATHER'S NAME Michael Wegeck		14. MOTHER'S MAIDEN NAME Eliz. Higdon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no or unknown) No		16. SOCIAL SECURITY NO 17. INFORMANT Family - same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Carcinomatosis Carcinoma of the cervix		1 year 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>September 9, 1958</u> to <u>March 26, 1959</u> , that I last saw the deceased alive on <u>March 24, 1959</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. <u>RFDS Bldg 442 Pasadena Md. March 26, 1959</u>	
ACTUAL SIGNATURE <u>R.M. McLaughlin</u>		DATE SIGNED <u>March 26, 1959</u>	
PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) 3.		22b. DATE THEREOF 3/30/59	
22c. NAME OF CEMETERY OR CREMATORIAL Glen Haven		22d. LOCATION (City, town, or county) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Dealey Funeral Home		24a. REGD. BY REGISTRAR MAR 30 1959 DATE	
		24b. REGISTRAR'S SIGNATURE Clinton S. Thrall	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02656

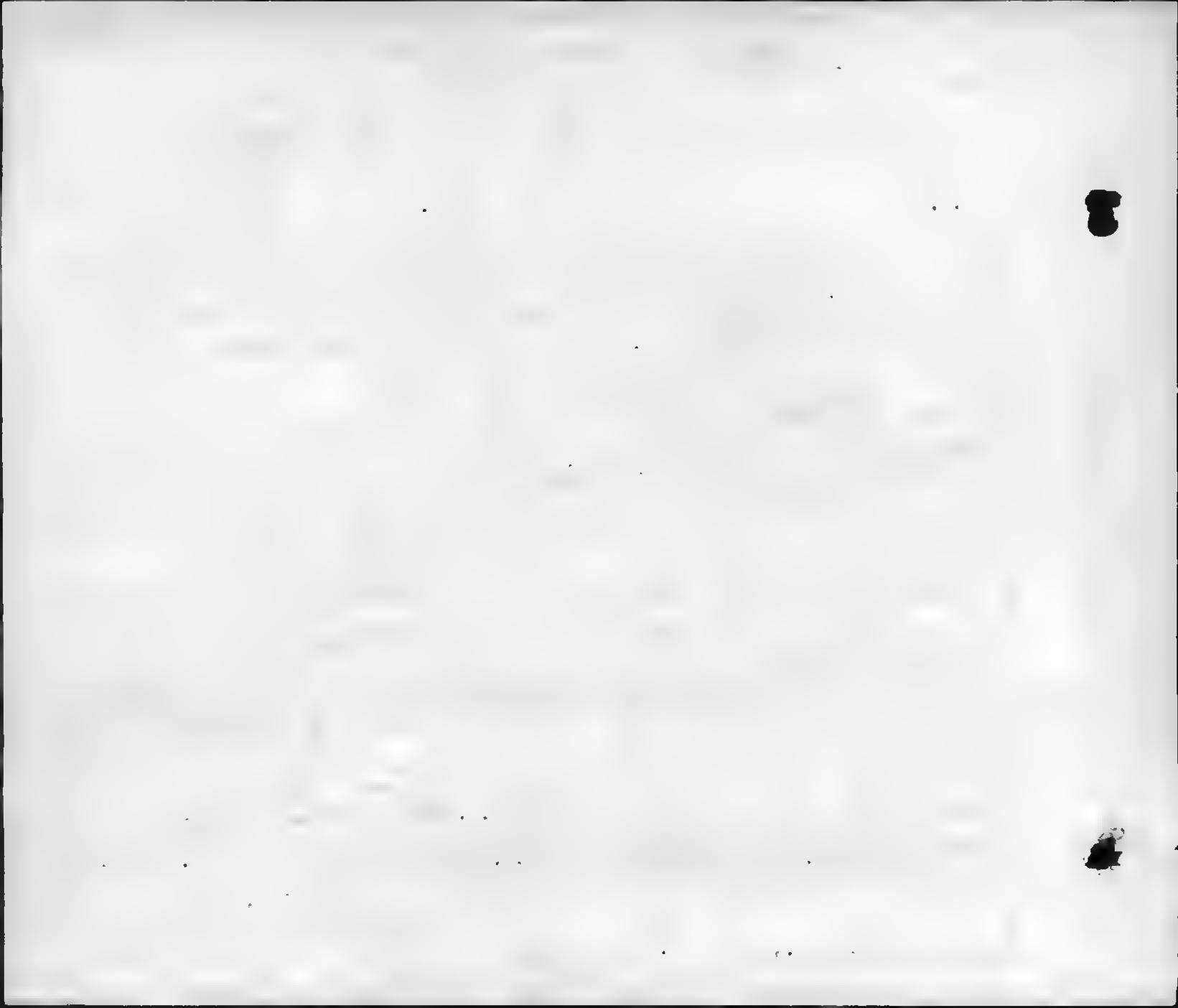
2681

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G Meade		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 417 W. Pratt St		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JOSEPH		First	Middle	Lost	4. DATE OF DEATH MILENSKAS	Month March	Day 11	Year 1959
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 Oct 1889	9. AGE (In years lost birthday) 69 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Russia (Maryample Lithuania USA		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME Joseph Milenskas		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WW 1 & WW II		
17. INFORMANT Mrs Adele Last 84 High St Sharon Hill, Pa		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 24IX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 10 days		
DUE TO COR Pulmonale		(b)		Chronic				
DUE TO Asthma		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour p. m.		Month 19	Doy 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Sharon Hill	(County) Westmoreland	(State) Pennsylvania
21. I certify that I attended the deceased from 11 March 1959, to 11 March 1959, that I last saw the deceased alive on 11 March 1959, and that death occurred at 0500 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fred W. Lafferty M.D. U.S. Army Hospital, Ft Meade, Md 11 Mar 59 DATE SIGNED								
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) FRED W. LAFFERTY, Capt, MC U.S. Army Hospital, Ft George G. Meade, Md						
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 3-12-59		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Cemetery		22d. LOCATION (City, town, or county) Drexel Hill, Pennsylvania (State)		
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

HOSPITAL ATTEND PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director, to funeral director, may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2682

CERTIFICATE OF DEATH

02657

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Epping Forest</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Epping Forest</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Maudie</i>	Middle <i>P</i>	Last <i>Miller</i>	4. DATE OF DEATH Month <i>March</i>	Day <i>17</i>	Year <i>1959</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-11-1890</i>	9. AGE (In years lost, birthday) <i>68 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if retired) <i>CLERK FENO R.R.CO.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>CLERK</i>		11. BIRTHPLACE (State or foreign country) <i>PENNA.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>EDGAR L. MILLER</i>		14. MOTHER'S MOTHER'S NAME <i>CORA Washington</i>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. R. G. Watts #2</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i>		DUE TO <i>CEREBRAL HEMORRHAGE</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 MINUTES</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>HYPERTENSIVE CARDIOVASCULAR DISEASE</i>		(c)		8 YEARS.			
Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>41 Southgate Ave</i>		20f. (City or town) <i>Annapolis, Md.</i>	(County) <i>Anne Arundel</i> (State) <i>Md.</i>
21. I certify that I attended the deceased from <i>3/17. 1959</i> to <i>3/17. 1959</i> , that I last saw the deceased alive on <i>3/17. 1959</i> , and that death occurred at <i>Annapolis, Md.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Edward S. Beck</i>		ADDRESS (Street, city or town, state) <i>41 Southgate Ave</i>		DATE SIGNED <i>3/17/59</i>			
PHYSICIAN'S NAME (Type) <i>Edward S. Beck</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-20-59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>North End Cemetery</i>		22d. LOCATION (City, town, or county) <i>Chambersburg</i> (State) <i>Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor & Sons</i>		ADDRESS <i>Annapolis, Md.</i>		24e. REC'D BY REGISTRAR <i>Mar 20 '59</i>		24f. REGISTRAR'S SIGNATURE <i>Arthur S. Keeler</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2621

CERTIFICATE OF DEATH

Reg. Dist. No. 02655

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis, Md.</i>			b. COUNTY <i>Anne Arundel</i>		
c. LENGTH OF STAY IN 1b <i>1 month</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General Hosp.</i>			d. STREET ADDRESS <i>1308 McKinley St.</i>		
3. NAME OF DECEASED (Type or print) <i>Bertha</i>			First <i>Bertha</i>	Middle <i>Mae</i>	Last <i>Hijekes</i>
4. DATE OF DEATH <i>3</i>			Month <i>3</i>	Day <i>6</i>	Year <i>1959</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>3-13-1882</i>	9. AGE (In years last birthday) <i>76 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Penna.</i>	IF UNDER 24 HRS. Days <i>0</i>
13. FATHER'S NAME <i>James J. Ayers</i>			14. MOTHER'S MAIDEN NAME <i>Elizabeth Bollinger</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>444-98-1234</i>	17. INFORMANT <i>Mrs. Gretchen Satchell</i>	Address <i>Warren, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic cardio-vascular</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs.</i>					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>diabetes mellitus, fractured ft. hip</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i>No</i>			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) <i>fell at home 12/21/58</i>		
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>12/21/58</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>home</i>	20f. (City or town) <i>Annapolis, Md.</i>
(County) <i>Annapolis, Md.</i>			(State) <i>Md.</i>		
21. I certify that I attended the deceased from <u>June</u> , 1954, to <u>March 7</u> , 1959 that I last saw the deceased alive on <u>March 6</u> , 1959, and that death occurred at <u>11:15</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Amos Garrett Blvd.</i>					
DATE SIGNED <i>3/7/59</i>					
ACTUAL SIGNATURE <i>S. Borssuck</i>					
PHYSICIAN'S NAME (Type) <i>S. Borssuck, M.D.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>					
22b. DATE THEREOF <i>3-9-1959</i>					
22c. NAME OF CEMETERY OR CREMATORIAL <i>Dunstontown Cemetery</i>					
22d. LOCATION (City, town, or county) <i>Rock Haven Pa.</i>					
(State) <i>Pa.</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Taylor & Sons Annapolis, Md.</i>					
ADDRESS <i>John H. Taylor & Sons Annapolis, Md.</i>					
24a. REC'D BY REGISTRAR <i>Arthur S. Krause</i>					
DATE MAR 11 '59					
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL COT: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

2622

CERTIFICATE OF DEATH

02659

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 1227 Tyler Ave	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RICHARD		First MIDDLE ALLEN		Last NICHOLS		4. DATE OF DEATH March 9 1959	Month Day Year
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1897	9. AGE (In years from birth) 61 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Linesman (Ret)		10b. KIND OF BUSINESS OR INDUSTRY Gas & Electric		11. BIRTHPLACE (State or Foreign country) Anne Arundel County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Luther M Nichols		14. MOTHER'S MAIDEN NAME Louise Anderson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or unknown, if yes, give war or date of service) No		16. SOCIAL SECURITY NO. 212-05-5961	
17. INFORMANT John Walter Nichols		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c)		19. ADDRESS Annapolis Defense Highway, Md.		INTERVAL BETWEEN ONSET AND DEATH 1 mo.	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		21. I certify that I attended the deceased from 2/18, 1959, to 3/5, 1959, that I last saw the deceased alive on 3/5, 1959, and that death occurred at M, from the causes and on the date stated above. ACTUAL SIGNATURE RICHARD N PEELER PHYSICIAN'S NAME (Type) R. RICHARD N PEELER, M.D.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/18, 1959, to 3/5, 1959, that I last saw the deceased alive on 3/5, 1959, and that death occurred at M, from the causes and on the date stated above. ACTUAL SIGNATURE RICHARD N PEELER PHYSICIAN'S NAME (Type) R. RICHARD N PEELER, M.D.		22. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 13, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Memorial	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR MAR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

1
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2683

CERTIFICATE OF DEATH

Reg. Dist. No.

102669

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dorsey		c. LENGTH OF STAY IN 1b 10 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dorsey (Hanover P.C.)		d. STREET ADDRESS Box 272 - Ohio Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 272 - Ohio Ave.				d. STREET ADDRESS Box 272 - Ohio Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) FRANK EDWARD		First	Middle	Lost	4. DATE OF DEATH OFFUTT, SR.	Month Month	Day Day	Year Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1899	9. AGE (In years last birthday) 59	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Coast Guard		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George W. Offutt		14. MOTHER'S MAIDEN NAME Agnes M. Stallings						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 111-12-6388		17. INFORMANT Mrs. Alois J. Offutt, Same As 12		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 144.7		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Carcinoma of Tongue Metastasized to Throat		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs 4 mos		
		DUE TO (c)		in Myocarditis		2 mos		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o.m. p.m.		20d. INJURY OCCURRED White of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 1609 Main St.		(County)	(State)
21. I certify that I attended the deceased from <u>Jan 1</u> , 1959, to <u>Mar 9</u> , 1959, that I last saw the deceased alive on <u>Mar 8</u> , 1959, and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>John Brembaugh</u>		ADDRESS (Street, city or town, state) 1609 Main St. DATE SIGNED <u>27 May 1959</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 13/59		22c. NAME OF CEMETERY OR CREMATORIUM Glen Haven		22d. LOCATION (City, town, or county) Glen Burnie, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. W. Huntington</u>		ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR MAR 12 '59		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>		

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

11 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12 Page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 2623 CERTIFICATE OF DEATH

Reg. Dist. No. 02661

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived) If institution, list date before admission a. STATE	
Anne Arundel MARYLAND		Maryland A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 26 Carver St.		d. STREET ADDRESS 26 Carver St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ira	Middle Lynn	Last Parker
4. DATE OF DEATH	Month 3	Day 22	Year 1959
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-12-1956
9. AGE (In years last birthday) 3 yrs	10. IF UNDER 1 YEAR Months . Days	11. IF UNDER 24 HRS. Hours . Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Parker	
14. MOTHER'S MAIDEN NAME Thelma Parker		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. <u>1</u> INFORMANT Thelma Parker, Anna, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 245X DUE TO <u>hypersensitivity response to penicillin</u> INTERVAL BETWEEN Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>administration of antibiotic</u> ONSET AND DEATH (c) about 2 1/2 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-22-59, 19, to 3-22-59, 19, that I last saw the deceased alive on 1-26-59, 19, and that death occurred at 10 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <u>Eric T. Allen</u> ADDRESS (Street, city or town, state) <u>62 Cathedral St.</u> DATE SIGNED <u>3-27-59</u> PHYSICIAN'S NAME (Type) <u>Eric T. Allen</u> Annapolis, Md.			
22. FUNERAL CREMATION, REMOVAL (SPECIMEN)		22b. DATE THEREOF	
Burial		3-25-59	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town or county) (State)	
Fowlers		Brent Vale, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
William Beese, D. Annapolis, Md.		ADDRESS	
24b. REGISTRAR'S SIGNATURE		DATE MAR 26 '59	
Arthur S. Kline			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02662

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>200 Severn Ave.</i>		d. STREET ADDRESS <i>200 Severn Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>William</i>		First <i>William</i>	Middle <i>E.</i>
4. DATE OF DEATH <i>3 - 19 1959</i>		Month <i>3</i>	Day <i>19</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>May 29-1875</i>		9. AGE (in years last birthday) <i>83</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Watchman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Watchman Shop Job</i>	11. BIRTHPLACE (State or foreign country) <i>La La Co Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>William S. Parks</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Ridgeway</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Address</i>	
17. INFORMANT <i>Mrs Leona Swink</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart disease</i>	
4344 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from: <i>1949</i> , 19, to <i>3/19</i> , 1959, that I last saw the deceased alive on <i>3/1/59</i> , 19, and that death occurred <i>12/45</i> , 1959, M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>E. R. Knobbe</i>		ADDRESS (Street, city or town, state) <i>Annapolis, Md.</i> DATE SIGNED <i>3/19/59</i>	
PHYSICIAN'S NAME (Type) <i>E. L. Wharff</i>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-22-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Bluff Cemt Annapolis</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons Annapolis Md.</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 23 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Price</i>



02663

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b <i>1 month</i>													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>A.A. General Hosp.</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>													
3. NAME OF DECEASED (Type or print)		First <i>William</i>	Middle <i>Dawson</i>	Last <i>Perry</i>	4. DATE OF DEATH <i>3 - 19 - 1959</i>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct-31-1902</i>		9. AGE (In years last birthday) <i>56</i> yrs.		10. IF UNDER 1YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>		11. IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>G.S.C.E.S.</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>CIVIL SERVICE</i>				11. BIRTHPLACE (State or foreign country) <i>A.A. Co Md</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>John Perry</i>				14. MOTHER'S MAIDEN NAME <i>Maggie Dawson</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>—</i>				17. INFORMANT <i>Margaret P. White</i> Address <i>2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>4544</i> DUE TO <i>Cardiac Disease</i>												Sudden					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Cardiac Disease</i>												(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour o. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .												DATE SIGNED <i>3/19/59</i>					
ACTUAL SIGNATURE <i>E. L. Whinck Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>													
EXAMINER'S NAME (Type) <i>E. L. Whinck Jr.</i>				22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>								22b. DATE THEREOF <i>3-21-59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>St. James Cemetery</i>		22d. LOCATION (City, town, or county) <i>Tracey's</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Son</i>				ADDRESS <i>Annapolis</i>								24a. REC'D BY REGISTRAR <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Hause</i>			
VS. A15ME(5) 5M 9/55				DATE <i>MAR 23 '59</i>								—		—			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

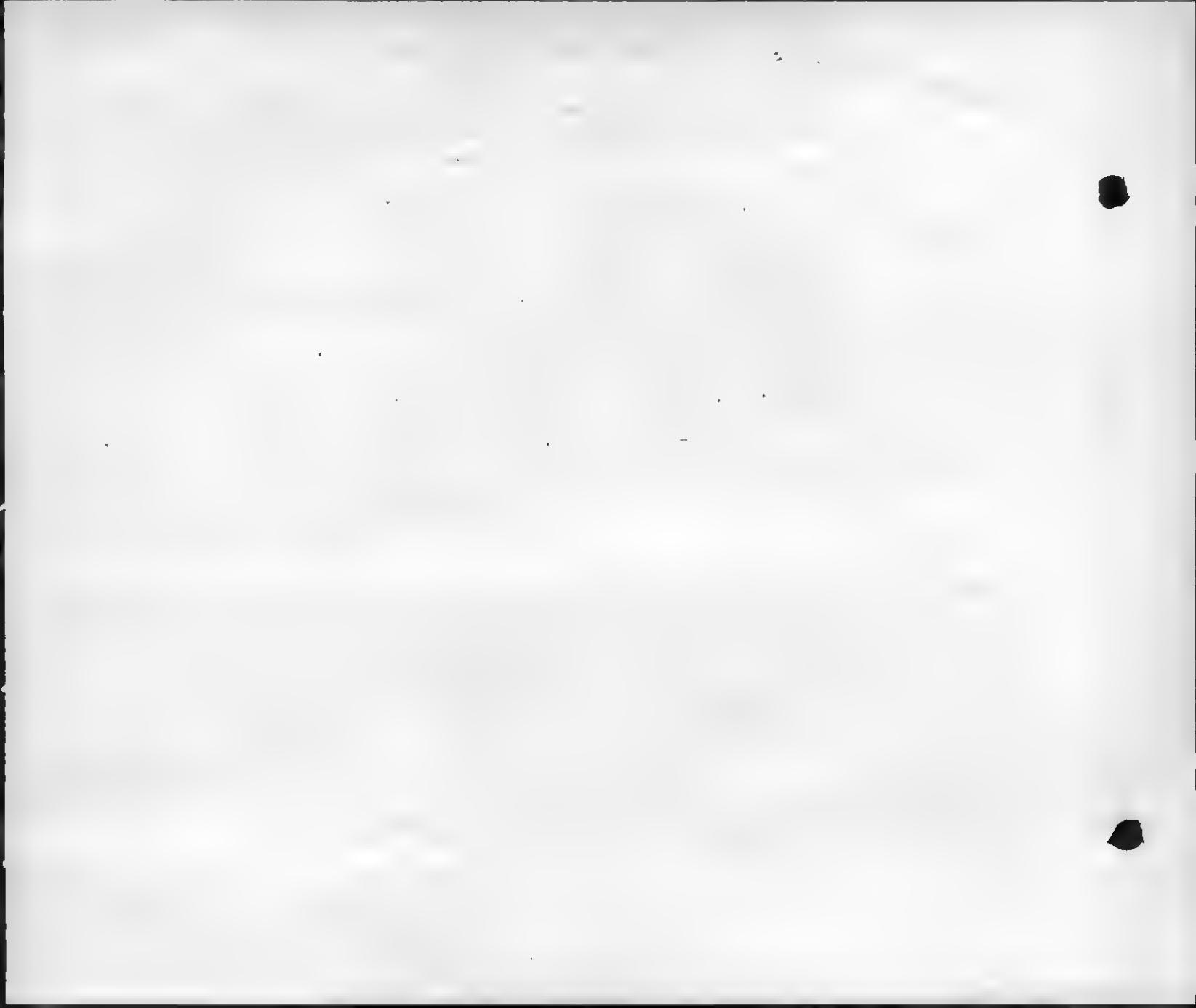
Item 1 File No. 2-30-29 et

02664

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn		b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b Severn, Md. Private home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 3403 Woodbine Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Thelma	Middle Agnes	Last Posey
4. DATE OF DEATH	Month J	Month J	Day 1
5. SEX	6. COLOR OR RACE Female	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1902
9. AGE (In years last birthday) 56 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 MRS Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Thomas Wm. Lovell		14. MOTHER'S MAIDEN NAME Sara Hopkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-22-1610	
17. INFORMANT J. Gardner Posey -3403 Woodbine Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH 14 days	
157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec</i> , 1958 to <i>March</i> , 1959, that I last saw the deceased alive on <i>March 4</i> , 1959, and that death occurred at <i>3 P. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John J. Deane</i>		ADDRESS (Street, city or town, state) M.D. <i>204 Crain Hg Glen Burnie</i> DATE SIGNED <i>3-5-59</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/9/1959	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ellsworth Armacost</i>		24a. REC'D BY REGISTRAR MAR 9 '59	
Ellsworth Armacost-4600 Liberty Hghts. Ave.		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02665

1. PLACE OF DEATH a. COUNTY		2626 A.A.C.O.		10, 11, 12, 13, 14		Film G-41 4-20-59 et		Reg. Dist. No.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		a. STATE MD		b. COUNTY AACO			
c. LENGTH OF STAY IN 16 Anne Arundel General		1 day		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Shady Side		IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		f. DATE OF DEATH		Month 3	Day 19	Year 1959			
3. NAME OF DECEASED (Type or print)		First Robert	Middle Potterfield	Lost	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min			
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	11b. KIND OF BUSINESS OR INDUSTRY Livestock dealer	11c. BIRTHPLACE (State or foreign country) Virginia	75 yrs					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Livestock dealer		10b. SOCIAL SECURITY NO.		17. INFORMANT MRS. DORIS WILDE		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Thomas Potterfield		14. MOTHER'S MAIDEN NAME Susan Coblenz		Address Shady Side Md.							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a), stating the underlying cause last. 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION STATED IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)		20c. TIME OF INJURY Month, Day, Year 3-18 1959			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Afro	(County) Md	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE E. L. Hardin		EXAMINER'S NAME (Type) E. L. Hardin		MD CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3-19-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/22/59		22c. NAME OF CEMETERY OR CREMATORIAL Lovettsville		22d. LOCATION (City, town or county) Lovettsville		(State) Va			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Lovettsville		24a. REC'D BY REGISTRAR DATE MAR 24 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Klaus					
VS A15ME 5M 2/57											



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2685

CERTIFICATE OF DEATH

Reg. Dist. No.

02666

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Queenstown - Severn		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Queenstown - Severn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 218 Queenstown - Severn		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Albert	Middle Last Queen	4. DATE OF DEATH Month March Day 29 Year 1959
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ambrose Queen		14. MOTHER'S MAIDEN NAME Annie Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Ethel Queen		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c) DUE TO <i>Cardiac Decompensation</i> DUE TO <i>Arteriosclerotic Cardio-Vascular Disease</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 13 , 1955, to March 29 , 1959, that I last saw the deceased alive on Feb. 27 , 1959, and that death occurred at 10 A.M. from the causes and on the date stated above		ADDRESS (Street, city or town, state) BRYANT L. JONES, M.D. 104 Crain Highway, South Glen Burnie, Maryland Phone: SO 6-3230	
ACTUAL SIGNATURE <i>Royce L. Jones</i>		DATE SIGNED 3/30/59	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-1-59	
22c. NAME OF CEMETERY OR CREMATORIAL Saints Rest		22d. LOCATION (City, town, or county) Harmons, A.A. Co., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Gloucester H. Gloucester</i>		ADDRESS 575	
		24a. REC'D BY REGISTRAR DATE APR 1 '59	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



FOR STATE
ALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
262 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02667

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)		b. STATE Maryland b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		917 31st St.		Annapolis		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Claude	Middle Randall	4. DATE OF DEATH	Month 3	Day 8	Year 1959

5. SEX male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6-30-1874	9. AGE (in years at birthday) 84 8/3 yrs.	10. KIND OF BUSINESS OR INDUSTRY B.W.A. Railroad	11. BIRTHPLACE (State or foreign country) A.A. Co. Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Columbus		14. MOTHER'S MAIDEN NAME Randall		15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO.	17. INFORMANT
						Selen Randall Annapolis, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

416.0

DUE TO

Burns generalized

INTERVAL BETWEEN
ONSET AND DEATH

Sudden

Conditions, if any, which
gave rise to immediate cause
(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Same fire				
20c. TIME OF INJURY Hour a. m. 10 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Annapolis	(County) Anne Arundel	(State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

Brewer

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

SP/BS

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-11-59	22c. NAME OF CEMETERY OR CREMATORIAL Brewer Still	22d. LOCATION (City, town, or county) Annapolis, Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE William Beese, Jr. Annapolis, Md.	ADDRESS	24a. REC'D BY REGISTRAR Arthur S. Trahan	24b. REGISTRAR'S SIGNATURE	
		DATE MAR 10 '59		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02668

Reg. Dist. No.

2628

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
Anne Arundel MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Annapolis	
Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		917 S. West St.	
917 S. West St.		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
Elizabeth		K	adall
4. DATE OF DEATH		Month	Day
3-4-1884		3	9
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
Female		Col.	3-4-1884
8. DATE OF BIRTH		9. AGE (In years from birthdate) 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		A.A. Co. Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
James Huntington		Maria Lebron	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
(No, or unknown)		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
916.0		Brewer - generalized	
DUE TO		seizures	
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.		Brewer - generalized	
DUE TO		seizures	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY	
Injury		Month, Day, Year	Hour
3-8 1959		o. m.	o. m.
20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		Home	
20f. (City or town)		(County)	
Annapolis		Anne Arundel	
(State)		(5 or 6)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. ACTUAL SIGNATURE	
E. Huntington		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
E. Huntington		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22d. BURIAL, CREMATION REMOVAL (Specify)		22e. DATE THEREOF	
Burial 3-11-59		22f. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
22g. LOCATION (City, town, or county)		(State)	
Annapolis, Md.		Anne Arundel	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
William Reese, Jr. - Annap. Md.		24b. REGISTRAR'S SIGNATURE	
		DATE MAR 10 '59	
		Author & Date	
VS. A15ME		SM 2:57	



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02669

2686

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY AA		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD		b. COUNTY AA					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRIENDSHIP		c. LENGTH OF STAY IN 1b 3 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROADWATER, DEALE		d. STREET ADDRESS					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First ELIZABETH	Middle JANE	Last RANDALL	4. DATE OF DEATH MARCH 14 1959	Month MARCH	Day 14	Year 1959			
5. SEX FEMALE		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 2 1870	9. AGE (In years lost birthday) 75 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. FATHER'S NAME Hall	14. MOTHER'S MAIDEN NAME UNKNOWN	15. CITIZEN OF WHAT COUNTRY? Prince George Co. Md. USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Prince George Co. Md.		12. ADDRESS					
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Era M. King Friendship Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. generalized arteriosclerosis DUE TO (b) hypertension (c)		19. INTERVAL BETWEEN ONSET AND DEATH			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woodfield		20f. (City or town) Trilesville		(County) Md.	(State) Md.		
21. I certify that I attended the deceased from not at all to 1959 , that I last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above. ACTUAL SIGNATURE Emily H. Inslam (partner, M.D.)		ADDRESS (Street, city or town, state) Trilesville, Md.		DATE SIGNED 3-17-59							
22a. BUR AL. CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/16/59		22c. NAME OF CEMETERY OR CREMATORIAL Woodfield		22d. LOCATION (City, town or county) Trilesville		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardisty		ADDRESS Trilesville, Md.		24a. REC'D BY REGISTRAR DATE MAR 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause					



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

111
 FOR STATE
 HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02670

Reg. Dist. No.

2629

1. PLACE OF DEATH a. COUNTY	Anne Arundel		MARYLAND	2. USUAL RESIDENCE (Where deceased lived or institution residence before admission) a. STATE	Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Annapolis			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	1706 N. Popular			
NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				
a. a. General Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First	Middle	George W. Randall	4. DATE OF DEATH	Month	Day	Year	
5. SEX	6. COLOR OR RACE	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS		
Male	Col.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2-13-1907	52 yrs	Months	Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)				
Laborer		Johnson Lumb. Co.		Harwood, Md.				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?				
George Randall		Martha Parker		U.S.A.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no. of unknown) <input type="checkbox"/> Yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause pertaining for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		
434.4		214-05-2496		Susie Randall - Annapolis, Md.		Cause of Disease		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b),		(b)		Address		INTERVAL BETWEEN DEATH AND DEATH HIDDEN		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)						
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE E. L.inkhardt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type)		DATE SIGNED 3/28/59						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, & county) (State)		
Burial		4-2-59		Brewer Hill		Annapolis, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
William Geese, Jr. - Annapolis, Md.				DATE MAR 31 '59		Arthur E. Linkhardt		
VS. A15M EM 2/57								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

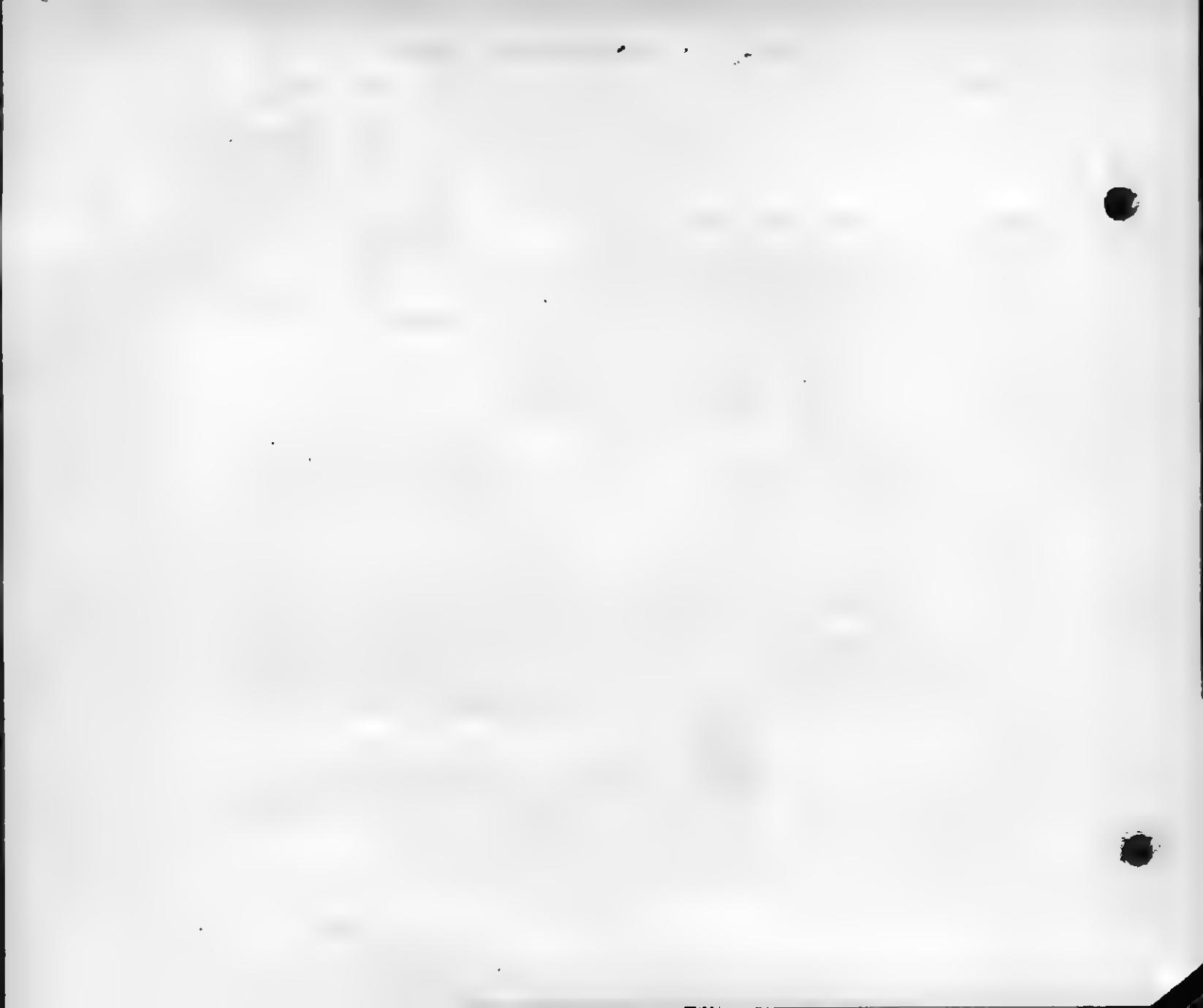
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2687

CERTIFICATE OF DEATH

Reg. Dist. No. 02671

1. PLACE OF DEATH a. COUNTY	Anne Arundel Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE	Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Severna Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Severna Park Md		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	27 yrs		d. STREET ADDRESS	Jumpers Hole Rd.		
3. NAME OF DECEASED (Type or print)	First	Middle	4. DATE OF DEATH	3 - 21 - 59	Month Day Year	
5. SEX	6. COLOR OR RACE	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH	79 yrs	8. IF UNDER 1 YEAR OF AGE (In years last birthday) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY			
Housewife	Home	Baltimore Md U.S.				
13. FATHER'S NAME	John Edward Kasmier		14. MOTHER'S MAIDEN NAME	George H. Regler		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address	BFD 1 Severna Park Box 411		
4		John Edward C. V. Westcott	INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO Causes of death C. V. Westcott						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 1957, 19, to 1957, 19, that I last saw the deceased alive on 3-19-59, 19, and that death occurred at 10:30 PM, from the causes and on the date stated above.						
ACTUAL SIGNATURE	Robert R. Hahn M.D. Severna Park					ADDRESS (Street, city or town, state)
PHYSICIAN'S NAME (Type)	Robert R. Hahn					DATE SIGNED 3-21-59
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/25/59	22c. NAME OF CEMETERY OR CREMATORIAL Most Holy Redeemer	22d. LOCATION (City, town, or county) Baltimore, Md.	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley, Glen Burnie, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE MAR 26 '59	24b. REGISTRAR'S SIGNATURE Catherine S. Thomas			



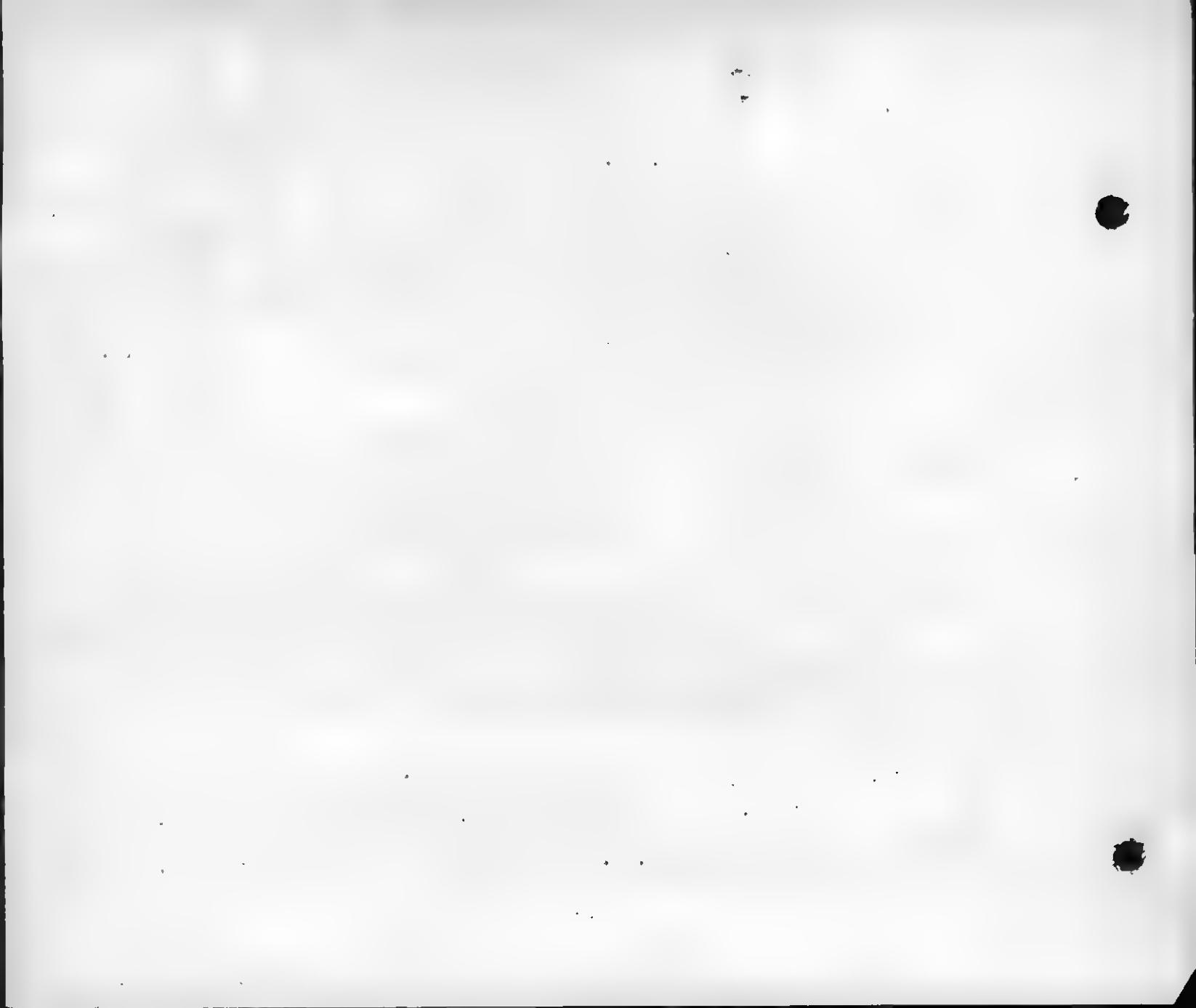
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2688

CERTIFICATE OF DEATH

Reg. Dist. No. 02672

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 45yr.4mo.23days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS Unknown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Sarah		First	Middle	Lost Revells	4. DATE OF DEATH 3	Month 3	Day 22	Year 19 59		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1894	9. AGE (In years lost birthday) 64 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.				
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Hospital Records		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Generalized and Cerebral Arteriosclerosis (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -----								
20c. TIME OF INJURY Hour a. m. ----- p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County) -----	(State) -----	
21. I certify that I attended the deceased from 10/29, 19 59, to 3/22, 19 59, that I last saw the deceased alive on 3/22, 19 59, and that death occurred at 6:32P.M., from the causes and on the date stated above. ACTUAL SIGNATURE: <i>Lionel McHenry Mapp</i>									ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.	DATE SIGNED 3/23/59
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3-26-59		22c. NAME OF CEMETERY OR CREMATORY Anatomy Board of Md.		22d. LOCATION (City, town, or county) Baltimore, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. McHenry Mapp</i>		ADDRESS		24a. REG'D BY REGISTRAR APR 2 '59 DATE		24b. REGISTRAR'S SIGNATURE <i>Charles S. Mapp</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE. 18

Items 8 & 9, Film 3544, 215) 17
CERTIFICATE OF DEATH

02673

Reg. Dist. No.

2600

1. PLACE OF DEATH a. COUNTY		5003 Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Patapsco Park 65		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		219 Bolivar Ave			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS 219 Bolivar Ave		d. STREET ADDRESS Patapsco Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First MON	Middle ROE	Lost	4. DATE OF DEATH	Month 3	Day 25	Year 1959	
5. SEX Male		6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-15-1866	9. AGE (In years last birthday) 92 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S. A.			
13. FATHER'S NAME James Reynolds		14. MOTHER'S MAIDEN NAME UNKNOWN							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Alice Reynolds - SAME		Address			
NO									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 49a X		DUE TO Lobar pneumonia				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO Senile debility							
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>March 2 1959</u> to <u>May 25 1959</u> , that I last saw the deceased alive on <u>3/26/59</u> , and that death occurred at <u>3/26/59</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Thos. J. Woolridge</u>		M.D.		ADDRESS (Street, city or town, state) <u>Box 212 Elkhorn Md.</u>		DATE SIGNED <u>3/27/59</u>			
PHYSICIAN'S NAME (Type) <u>Thos. J. Woolridge</u>									
22a. BURIAL, CREMATION, REMOVAL? (Specify) BURIAL		22b. DATE THEREOF 3-28-59		22c. NAME OF CEMETERY OR CREMATORIUM Mt Calvary Cemetery		22d. LOCATION (City, town, or county) Cedar Hill Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy D. Wilson</u>		ADDRESS <u>1000 Grantley Ave</u>		24a. REC'D BY REGISTRAR DATE APR 6 '59		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

DO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be ~~replaced~~ by the hospital or attending physician.

DO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02674

CERTIFICATE OF DEATH

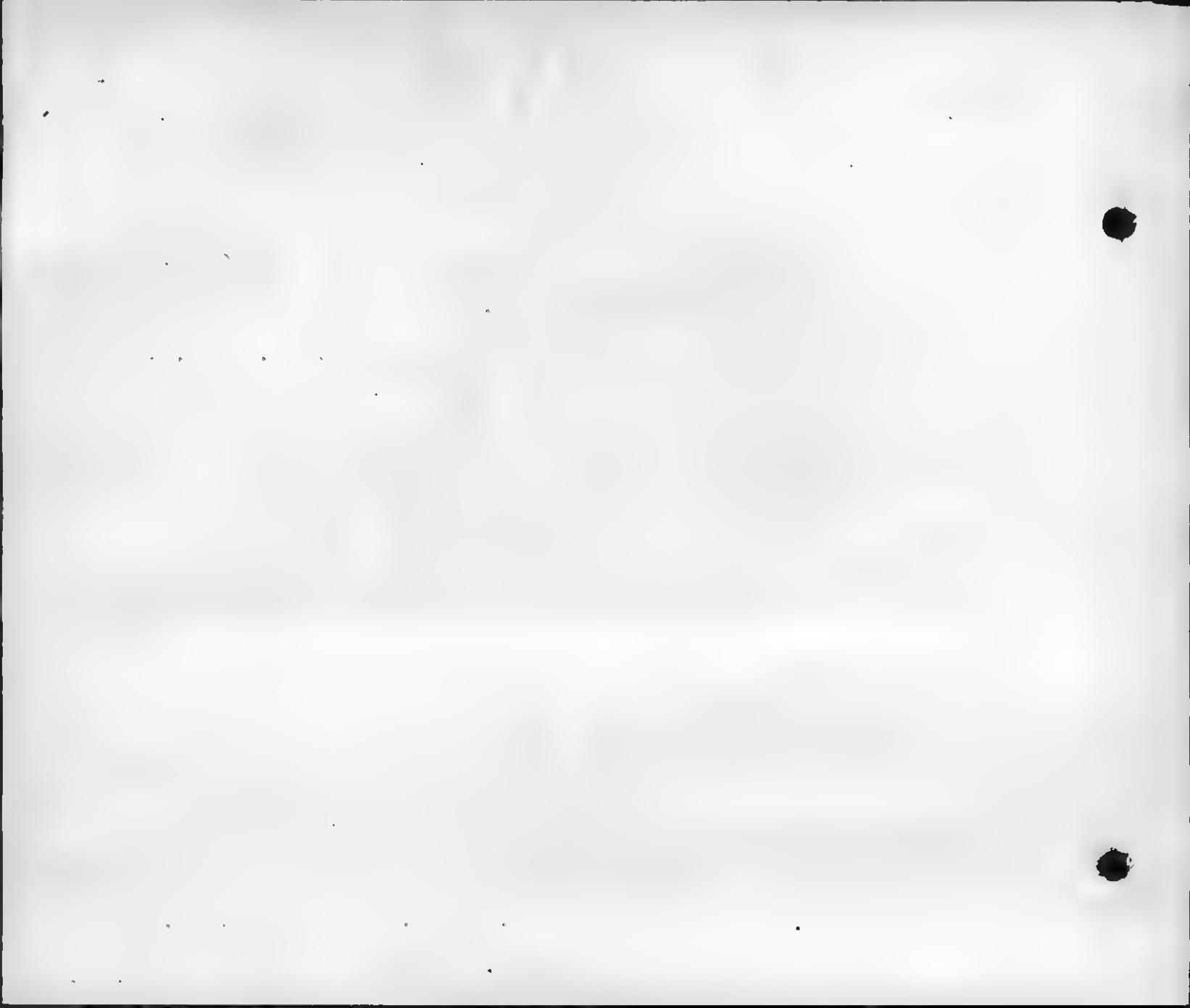
Reg. Dist. No.

2690				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)				
1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		a. STATE Maryland		b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		d. STREET ADDRESS 605 Newfield Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 605 Newfield Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) AGNES P. ROBERTS		First	Middle	Last	4. DATE OF DEATH March 5,	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7, 1891	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months		IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Eagles 5/10 store		11. BIRTHPLACE (State or foreign country) Pittsburgh, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Ferdinand Probst		14. MOTHER'S MAIDEN NAME Mary Geiser						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no		16. SOCIAL SECURITY NO. 219-32-5194		17. INFORMANT Mrs. Mayme Holt		Address Same As #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause if any. (b) DUE TO (c)		2. Respiratory Failure		3. Pulmonary Metastasis		4. INTERVAL BETWEEN ONSET AND DEATH 10 mos		
4. Pulmonary Hepatic Malignancy		5. Senility				6 mos		
5. Senility		6. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)				7. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from _____, 19____ to _____, 19____ that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____ M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>B.W. Richard</i> M.D.		22. NAME OF CEMETERY OR CREMATORIAL ADDRESS 715 Coopers Rd Glen Burnie MD 21211 Maryland		22d. LOCATION (City, town, or county) Pittsburgh, Pa.		ADDRESS (Street, city, town, state) DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 9, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Allegheny Co. Mem. Pk.		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard V. Sington</i>		ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE MAR 9 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the page should be detached for use as the burial-transit permit. Then please remove carbon paper, sign and file with the registrar or prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 film 3234 3-4-59 et

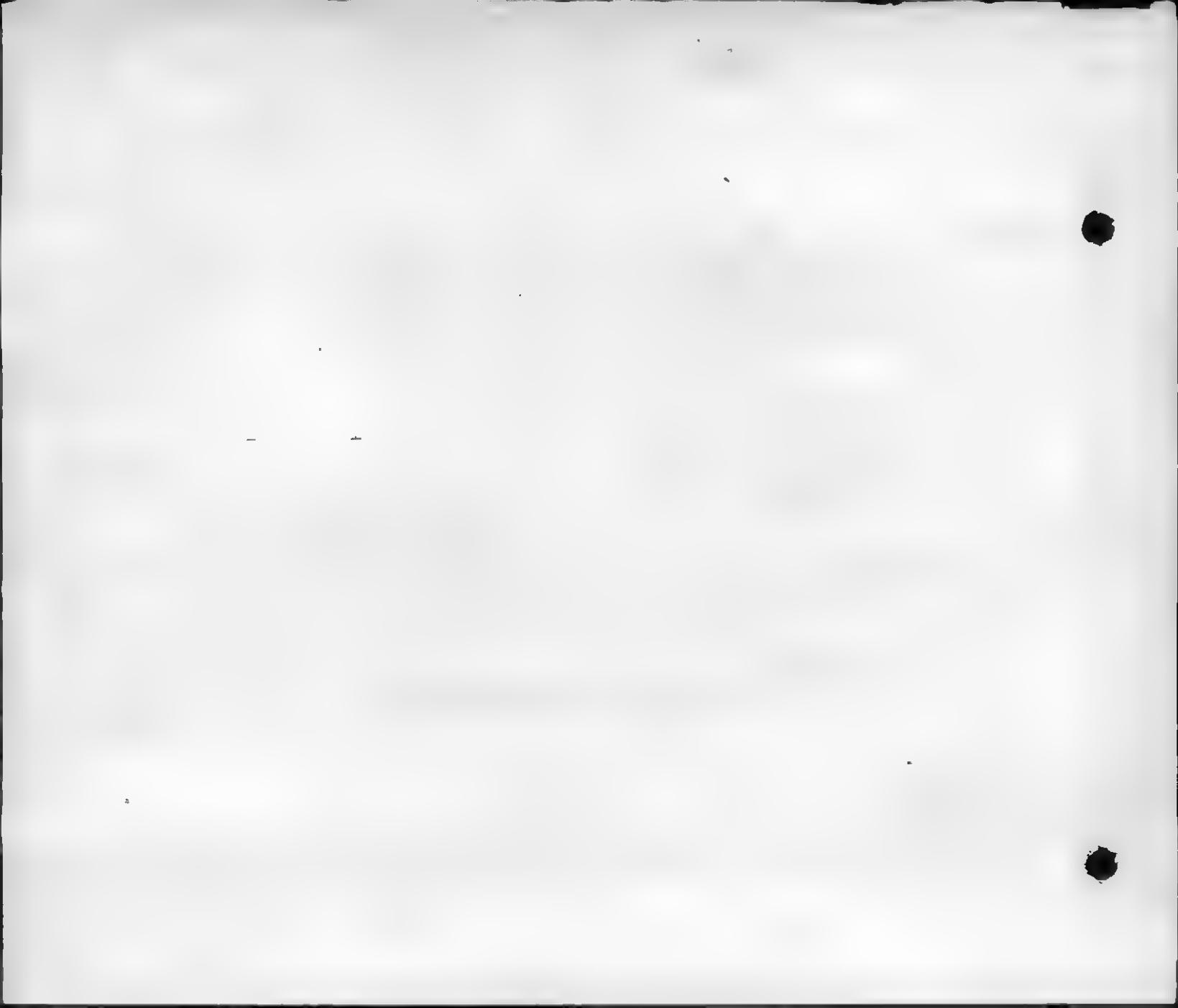
02675

2630

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annarolis		b. COUNTY Anne Arundel	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General		d. STREET ADDRESS 305 Severn Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) KATHERINE	First M	Middle ROBERTS	Last Month March Day 1 Year 19 59
4. DATE OF DEATH	5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Sept. 1, 1904	9. AGE (In years last birthday) 17 54 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ho sewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AUGUSTA HAUCK		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT CARROLL P R BERTS Husband- Same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH years	
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 420.1		Acute Coronary Thrombosis	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Antihypertensive, C. & A. Mixture	
DUE TO (b) DUE TO (c)		C tryptidine.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 28, 1959, to Mar 1, 1959, that I last saw the deceased alive on Mar 1, 1959, and that death occurred at 2 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Annapolis, Md. DATE SIGNED 3/3/59	
ACTUAL SIGNATURE MAURICE F. ALAWANS, M.D.		21. Southgate Ave., Annapolis, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 4, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HUFFING FUNERAL HOME, Annapolis, Maryland		24a. REC'D BY REGISTRAR DATE MAR 5 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02676

1. PLACE OF DEATH a. COUNTY		2691 Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 3 yrs.		d. STATE Maryland	
GLEN BURNIE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY A.A. County	
d. NAME OF HOSPITAL (If not in hospital, give street address) FOREST OR INSTITUTION Box 117 R.F.D. 5 Beechwood		d. STREET ADDRESS Box 117 R.F.D. 5 Beechwood		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Le Roy		First E.	Middle	4. DATE OF DEATH	Month MARCH Year 27, 1959
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1874	9. AGE (In years lost birthday) 87 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police man		10b. KIND OF BUSINESS OR INDUSTRY BALTO. City		11. BIRTHPLACE (State or foreign country) MARYLAND, CALVERT CO.	
13. FATHER'S NAME John Robinson		14. MOTHER'S MAIDEN NAME MARGARET V. BORDLEY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes or no or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT Box 117 R.F.D. 5 Mrs. Harry L. Miller	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Arteriosclerotic Cardiovascular disease</i> DUE TO (c) <i>with cardiac decompensation</i>				INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus, 24 years duration</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec. 16, 1958</i> , to <i>March 27, 1959</i> , that I last saw the deceased alive on <i>March 25, 1959</i> , and that death occurred at <i>7:00 A.M.</i> from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) <i>Box 117 R.F.D. 5, Pasadena Md.</i> DATE SIGNED <i>March 27, 1959</i>					
ACTUAL SIGNATURE <i>R.M. McLaughlin</i>		M.D.			
PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 30-1959		22c. NAME OF CEMETERY OR CREMATORIAL London Park Cem.	
22d. LOCATION (City, town, or county) Baltimore Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>S. Truman Schub</i>		ADDRESS 3512 Frederick Ave (29)		24a. REC'D BY REGISTRAR MAR 30 1959 DATE	
				24b. REGISTRAR'S SIGNATURE <i>C. Lewis S. Krause</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. A copy should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02677

Reg. Dist. No.

2692

1. PLACE OF DEATH a. COUNTY Falls Church		2. USUAL RESIDENCE (Where deceased lived if institution or residence before admission) a. STATE Md. b. COUNTY Falls Church	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) S. Virginia Park		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) S. Virginia Park		d. STREET ADDRESS Bentfield Rd	
3. NAME OF DECEASED (Type or print) James		First M.	Middle Saffield
4. DATE OF DEATH 3	Month Mar	Day 23	Year 1957
5. SEX Male	6. COLOR OR RACE white	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED
8. DATE OF BIRTH March 18, 1881		9. AGE (In years from birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY State of Md.	
11. BIRTHPLACE (State or foreign country) A.A.Ct. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Saffield		14. MOTHER'S MAIDEN NAME Mary Stevens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 211-26-6741 17. INFORMANT Lucy Saffield Bentfield R1. Soveriar	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), <u>storing the underlying</u> cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. F. Ward		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 3/23/57			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/21/59	
22c. NAME OF CEMETERY OR CREMATORIAL Glen Haven		22d. LOCATION (City, town, or county) Rite of Life N. H. B. J. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Schweinberg Funeral Service 1126 J. Street, Baltimore, Md. u & Schweinberg		ADDRESS 24a. REC'D BY REGISTRAR DATE MAR 26 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

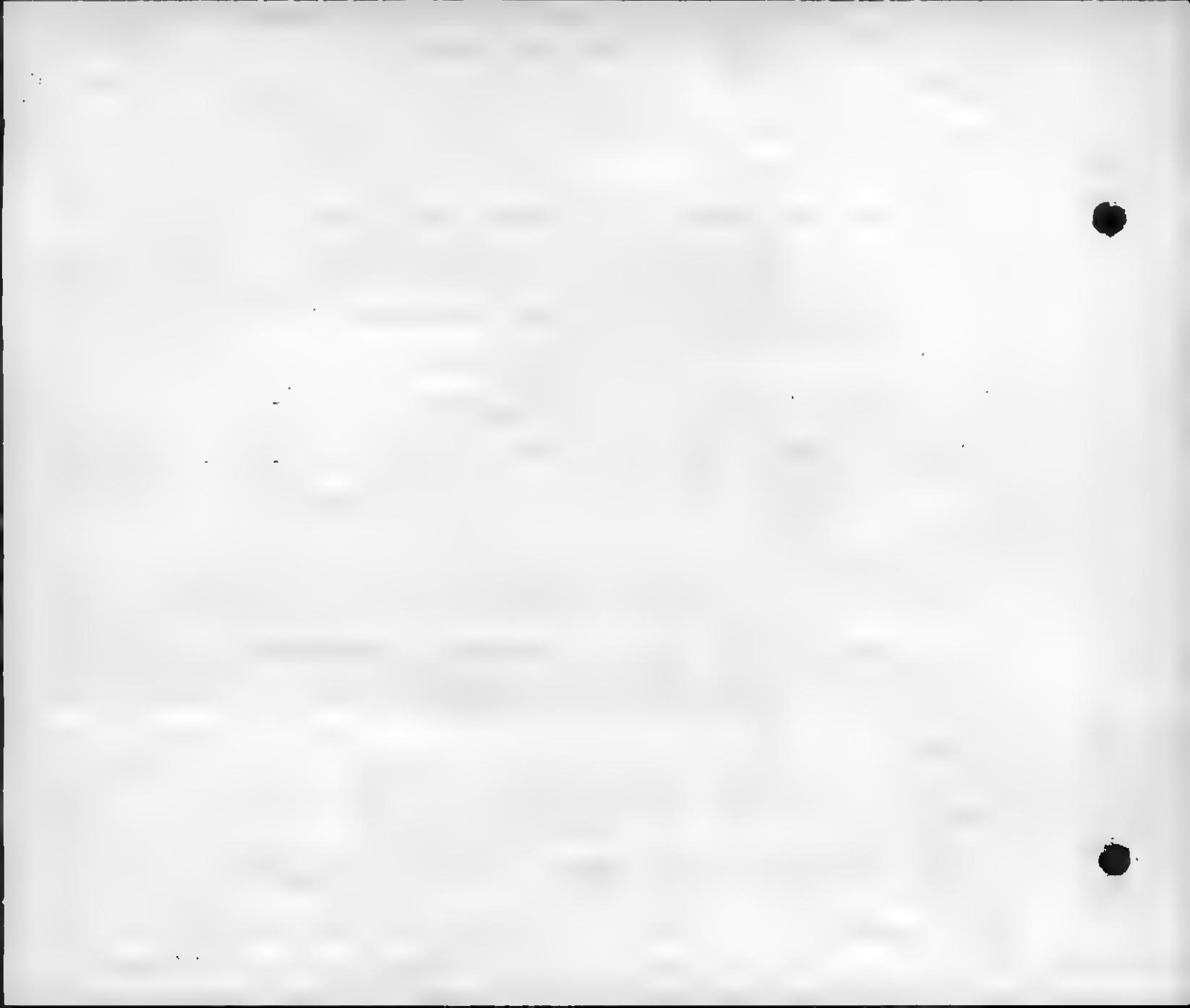
2631

CERTIFICATE OF DEATH

02678

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
a a MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) General Hosp		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
3. NAME OF DECEASED (Type or print)		d. STREET ADDRESS 309 Gibson Road	
First Ellwood P.		Middle Schreger	
Last Schreger		4. DATE OF DEATH	Month 3
5. SEX Male		Day 15	Year 1959
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6-27-1898		9. AGE (In years from birth) 60 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret Sheet Metal Works Naval Academy		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Annapolis Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John K. Schreger	
14. MOTHER'S MAIDEN NAME Maggie Jacobs		15. WAS DECEASED EVER IN U. S. ARMED FORCES YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes, give war or date of service) World War I	
16. SOCIAL SECURITY NO.		17. INFORMANT Elizabeth E. Schreger	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 400.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/15, 1959, to 3/15, 1959, that I last saw the deceased alive on 3/15, 1959, and that death occurred at 8:30 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE Richard N. Reeler M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-18-59	
22c. NAME OF CEMETERY OR CREMATORIUM St. Anne's Cemetery		22d. LOCATION (City, town, or county) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons		24a. REC'D BY REGISTRAR DATE MAR 19 '59	
ADDRESS Annapolis Md		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be removed by the hospital or attending physician.

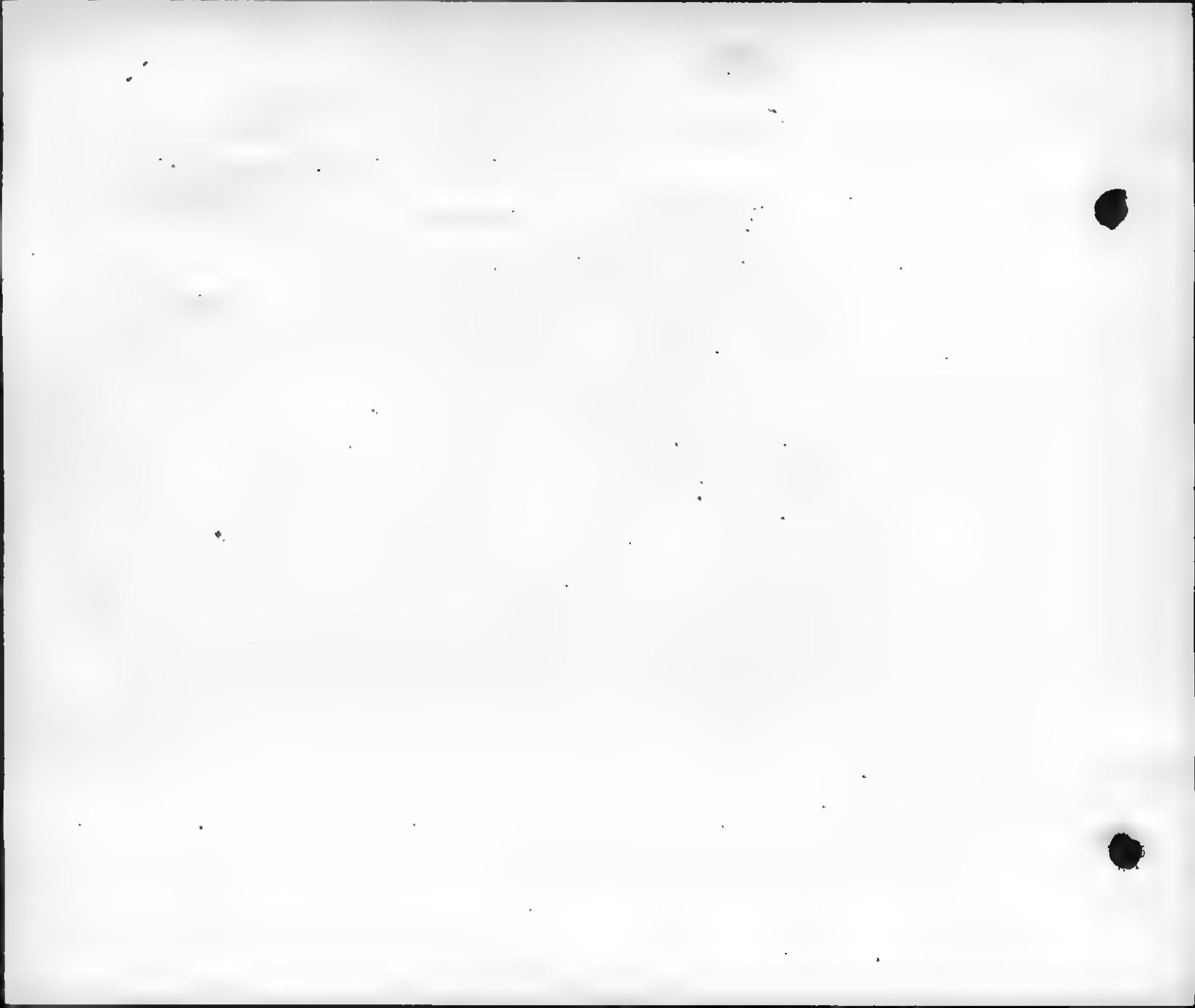
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 a. and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Items 8, 9, 14, Film 625111-10-59, E.S. 02639

CERTIFICATE OF DEATH

Reg. Dist. No. 2632

1. PLACE OF DEATH a. COUNTY <i>A.A. County</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL and Annapolis</i>		b. COUNTY <i>A. A. Co.</i>	
c. LENGTH OF STAY IN 1b <i>1b</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>1b</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A.A. General</i>		d. STREET ADDRESS <i>Patuxent Roads, Annapolis, Maryland</i>	
3. NAME OF DECEASED (Type or print) <i>Franklin E. Sharp</i>		First <i>Franklin</i>	Middle <i>E.</i>
4. DATE OF DEATH <i>3 30 1959</i>		Last <i>Sharp</i>	Month <i>3</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>January 9, 1959</i>		9. AGE (In years 1st birthday) <i>47</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Painter</i>	
10c. BIRTHPLACE (State or foreign country) <i>Annapolis, Maryland</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Frank L. Sharp</i>		14. MOTHER'S MAIDEN NAME <i>Louise B. Russell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Frank L. Sharp - Patuxent Rd Odenton</i>		Address <i>Frank L. Sharp - Patuxent Rd Odenton</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Peritusis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 WKS</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b) <i>Intussusception</i>		DUE TO <i>Peritusis</i>	
DUE TO <i>Intussusception</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
DUE TO <i>Intussusception</i>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Intussusception, sigmoid, with perforation of sigmoid and peritonitis</i>	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) (County) (State) <i>None</i>	
21. I certify that I attended the deceased from <i>20 Mar</i> , 19 <i>59</i> , to <i>30 Mar</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>30 March</i> , 19 <i>59</i> , and that death occurred at <i>10:00 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>John K. Walker, M.D.</i>		ADDRESS (Street, city or town, state) <i>121 Cathedral St, Annapolis, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/2/59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore Nat'l Cemetery</i>		22d. LOCATION (City, town, or county) <i>Baltimore, City</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Thomas</i>		24a. REC'D BY REGISTRAR DATE <i>APR 6 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2633

CERTIFICATE OF DEATH

02680

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>1 week</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. J. General</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. STREET ADDRESS <i>115 Conduit</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mora F. Simmons</i>		4. DATE OF DEATH Month <i>3 - Day 9 Year 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 3-1907</i>
9. AGE (in years lost birthday) yrs. <i>51</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
10c. BIRTHPLACE (State or foreign country) <i>Benedict Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Geo A. Springfield</i>		14. MOTHER'S MAIDEN NAME <i>Anna Hurley</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>George A. Simmons (2)</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Hydrocephrosis</i> DUE TO (c)	
		19. INTERVAL BETWEEN ONSET AND DEATH <i>72 hours</i>	
		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>HEPATITIS. INFECTIONS</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9/26/1958</i> to <i>3/9/1959</i> that I last saw the deceased alive on <i>3/9/1959</i> , and that death occurred at <i>3307 M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edward J. Beck</i>		ADDRESS (Street, city or town, state) <i>M.D. 41 Southgate Ave. Annapolis, Md.</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <i>3/11/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-12-59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Hillcrest Cemetery</i>		22d. LOCATION (City, town, or county) <i>Annapolis Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons Annapolis Md.</i>		24a. REC'D BY REGISTRAR <i>Mar 12 '59</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Edward J. Beck</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0268!

2634

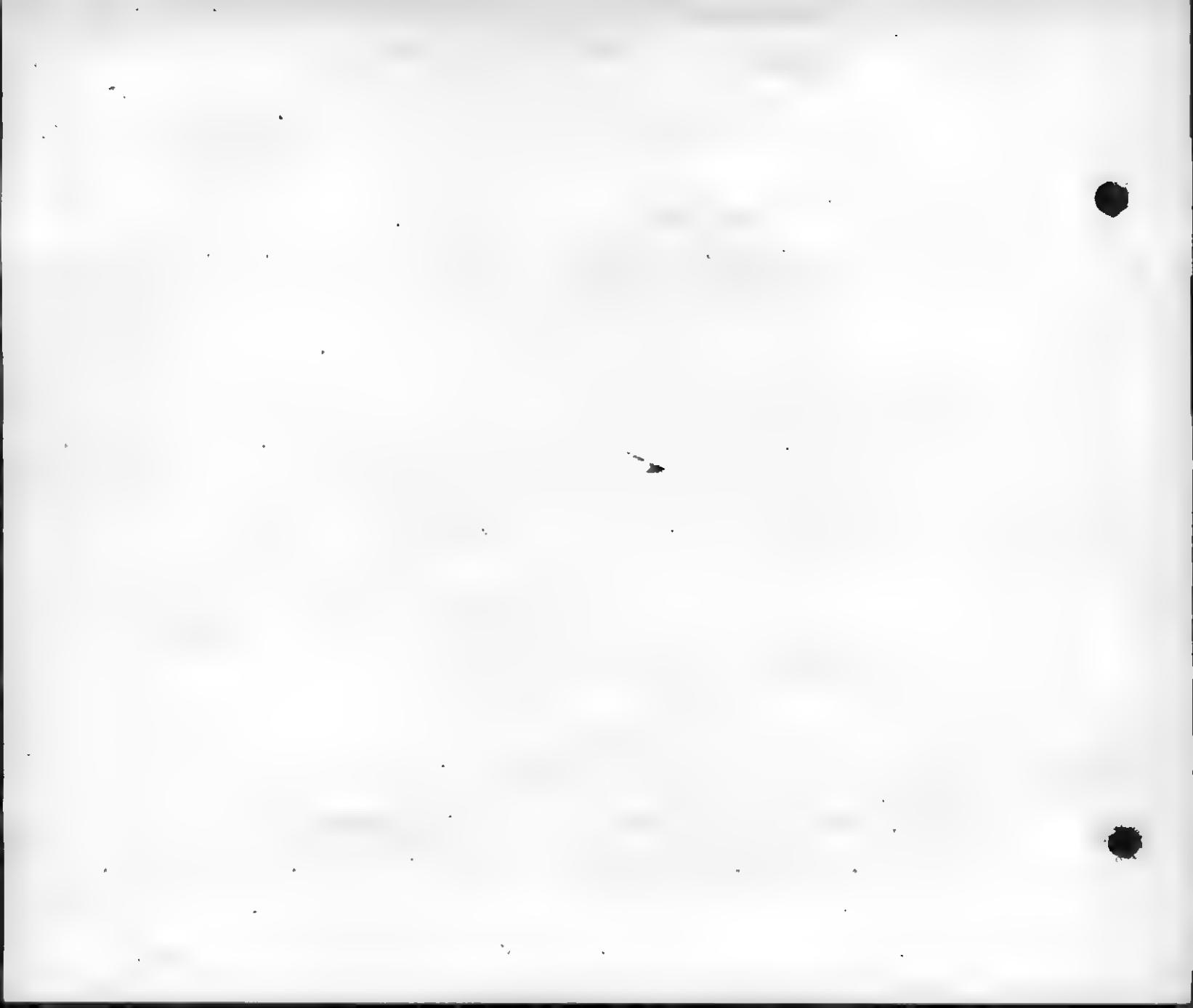
CERTIFICATE OF DEATH

Reg. Dist. No.

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed in page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marley (Glen Burnie, Md.)		d. STREET ADDRESS 201-1911 Marley Park, Glen Burnie, Md.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Florence		First	Middle	Last	4. DATE OF DEATH March 12	Month	Day	Year 19 59
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 11, 1959		9. AGE (In years last birthday) yrs. 17	10. IF UNDER 1 YEAR Months 17	11. IF UNDER 24 HRS Days 35
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 10c. BIRTHPLACE (State or foreign country) Annapolis, Md.						12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME William Franklin Smith		14. MOTHER'S MAIDEN NAME Ruth Elaine Ross						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 110-12-1212		INFORMANT Mother		Address Marley Park, Glen Burnie, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 771 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO DUE TO (c)		Pneumaturity (Rubrum Exan.)				INTERVAL BETWEEN ONSET AND DEATH 771 to 30 min.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Annapolis	(County)	(State)		
21. I certify that I attended the deceased from <u>Mar. 11, 1959</u> to <u>Mar. 12, 1959</u> , that I last saw the deceased alive on <u>Mar. 12, 1959</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 144 Southgate Ave., Annapolis, Md.		DATE SIGNED Albert L. Anderson		
ACTUAL SIGNATURE Dr. Albert L. Anderson		PHYSICIAN'S NAME (Type)		21. LOCATION (City, town, or county)		(State)		
22a. BURIAL, CREMATION, REMOVAL (Specify) Funeral Home		22b. DATE THEREOF Mar. 14, 1959	22c. NAME OF CEMETERY OR CREMATORIAL Glen Burnie	22d. LOCATION (City, town, or county)		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE F. L. Anderson		ADDRESS 61-10-12-1111		24a. REC'D BY REGISTRAR MAR 16 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2693

CERTIFICATE OF DEATH

Reg. Dist. No. 02682

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)			
Anne Arundel MARYLAND		a. STATE Maryland	b. COUNTY A.A.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 1 Box 436		e. STREET ADDRESS Route 1 Box 436			
3. NAME OF DECEASED (Type or print) Viola		4. DATE OF DEATH 3	Month 31 Year 1959		
5. SEX Female		6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH 12-19-1894		9. AGE (In years (out-birthday) 64 yrs			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Millersville, Md.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Hall			
14. MOTHER'S MAIDEN NAME Martha Smith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? YES <input type="checkbox"/> NO <input type="checkbox"/> III. yes, give war or dates of service 1970			
16. SOCIAL SECURITY NO		17. INFORMANT Maudie Johnson Millersville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for Part I (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 454.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Baltimore, Md.	
20g. (City or town) Baltimore, Md.		(County) Baltimore Co.		(State) Md.	
21. I certify that I attended the deceased from 9-12-58, 19 to 3-31-59, 19, that I last saw the deceased alive on 3-30-59, 19, and that death occurred at 7 1/2 M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>E.P. Allen</i> ADDRESS (Street, city or town, state) 66 Cathedral St Baltimore, Md. DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-4-59		22c. NAME OF CEMETERY OR CREMATORIUM John Stesley	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese		ADDRESS 1000 N. Wolfe St., Baltimore, Md.		24a. REC'D BY REGISTRAR APR 3 '59	
24b. REGISTRAR'S SIGNATURE C. W. Hause					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02683

2694

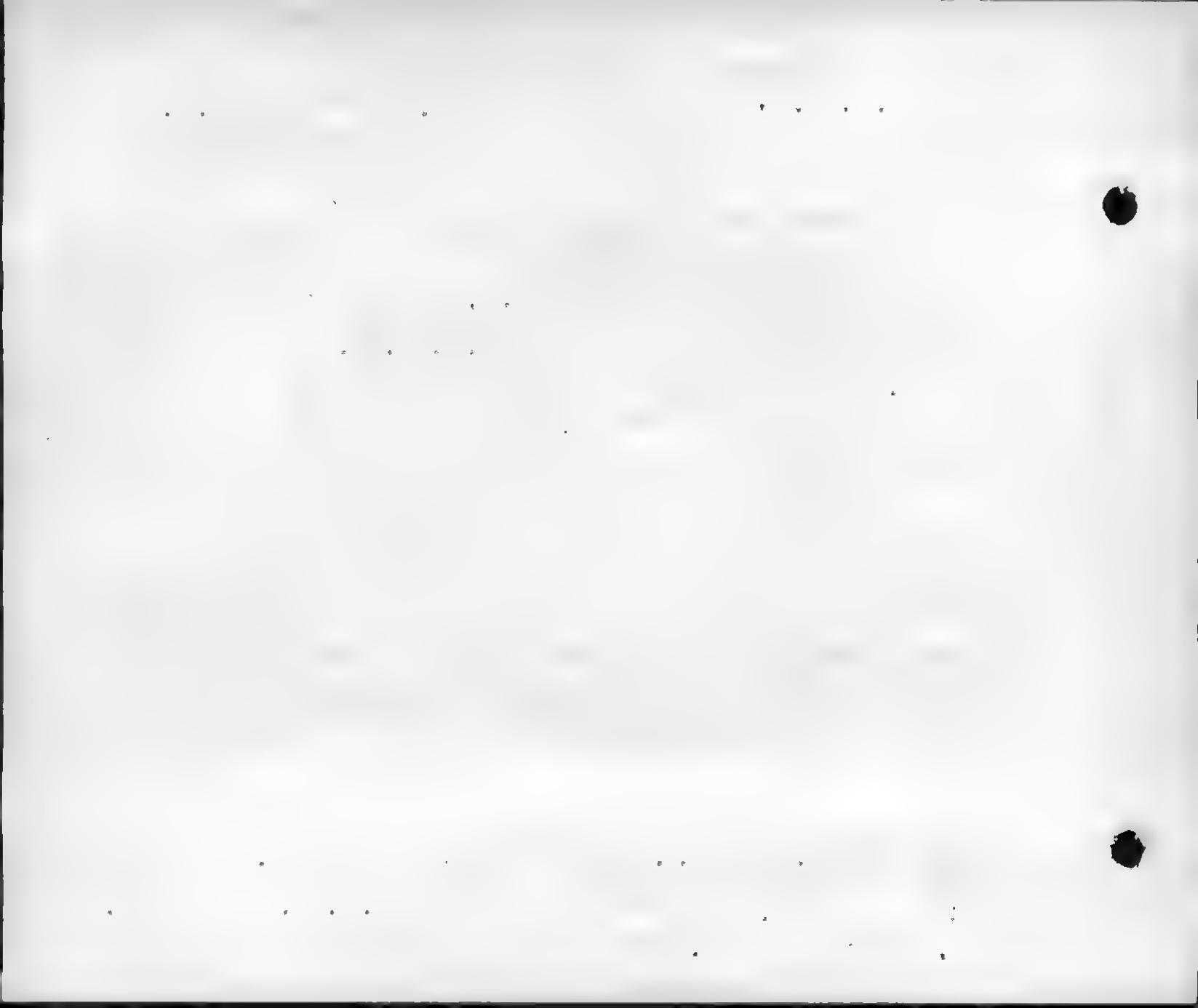
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A. A. Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY A. A. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ordnance Rd. Curtis Bay		c. LENGTH OF STAY IN life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Curtis Bay	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Ordnance Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Stella	Middle Hammond	Last Stoll	4. DATE OF DEATH Month March Day 20, Year 1959
5. SEX Female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1879	9. AGE (In years less birthday) 79 yrs. 12. CITIZEN OF WHAT COUNTRY? A. A. Co. Md.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) A. A. Co. Md.	
13. FATHER'S NAME John T. Hammond		14. MOTHER'S MAIDEN NAME Camsadel Shipley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Dorothy S. Oxley 1004 Stewart Lane Address Glen Burnie Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) Myocardial Failure Gastritis		INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-14-1959 to 3-20-1959, that I last saw the deceased alive on 3-14-1959, and that death occurred at 12:45 AM, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 320 Patapsco Ave.	
ACTUAL SIGNATURE Louis J. Glass M.D.		DATE SIGNED 3/20/59			
PHYSICIAN'S NAME (Type) Louis J. Glass M.D.		320 Patapsco Ave.			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF March 23, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill	
22d. LOCATION (City, town, or county) A. A. Co.		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc.		ADDRESS 1900 Eutaw Place		24a. REC'D BY REGISTRAR MAR 23 '59 DATE	
				24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2695

CERTIFICATE OF DEATH

Reg. Dist. No. 02681

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE		c. LENGTH OF STAY IN 1b 9 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROWNSVILLE		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IRVING		Middle —	
4. DATE OF DEATH THOMAS		Month 3	
5. SEX Male		Day 14	
6. COLOR OR RACE N		Year 1959	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 14, 1909	
9. AGE (In years last birthday) 49 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY rural	
10c. BIRTHPLACE (State or foreign country) Md USA		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Charles Thomas (deceased)		14. MOTHER'S MAIDEN NAME Anne Thomas (deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or date of service) No		17. INFORMANT HOSPITAL RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 223X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Pneumonitis Hemiplegia post surgical. Sub-dural Hygroma.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 224 Syphilis & Decubitus Ulcers.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19 _____, to _____, 19 _____, that I last saw the deceased alive on _____, 19 _____, and that death occurred at _____, 9:15 P.M., from the causes and on the date stated above ACTUAL SIGNATURE Xavier McHenry Mapp M.D.		ADDRESS (Street, city or town, state) Crownsville State Hospital DATE SIGNED Crownsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 18, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL THOMESONTOWN CEMETERY		22d. LOCATION (City, town, or county) NEAR EAST Main MARKET, MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Fransett & Son, Undertakers, Md.		24a. REC'D BY REGISTRAR DATE MAR 17 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



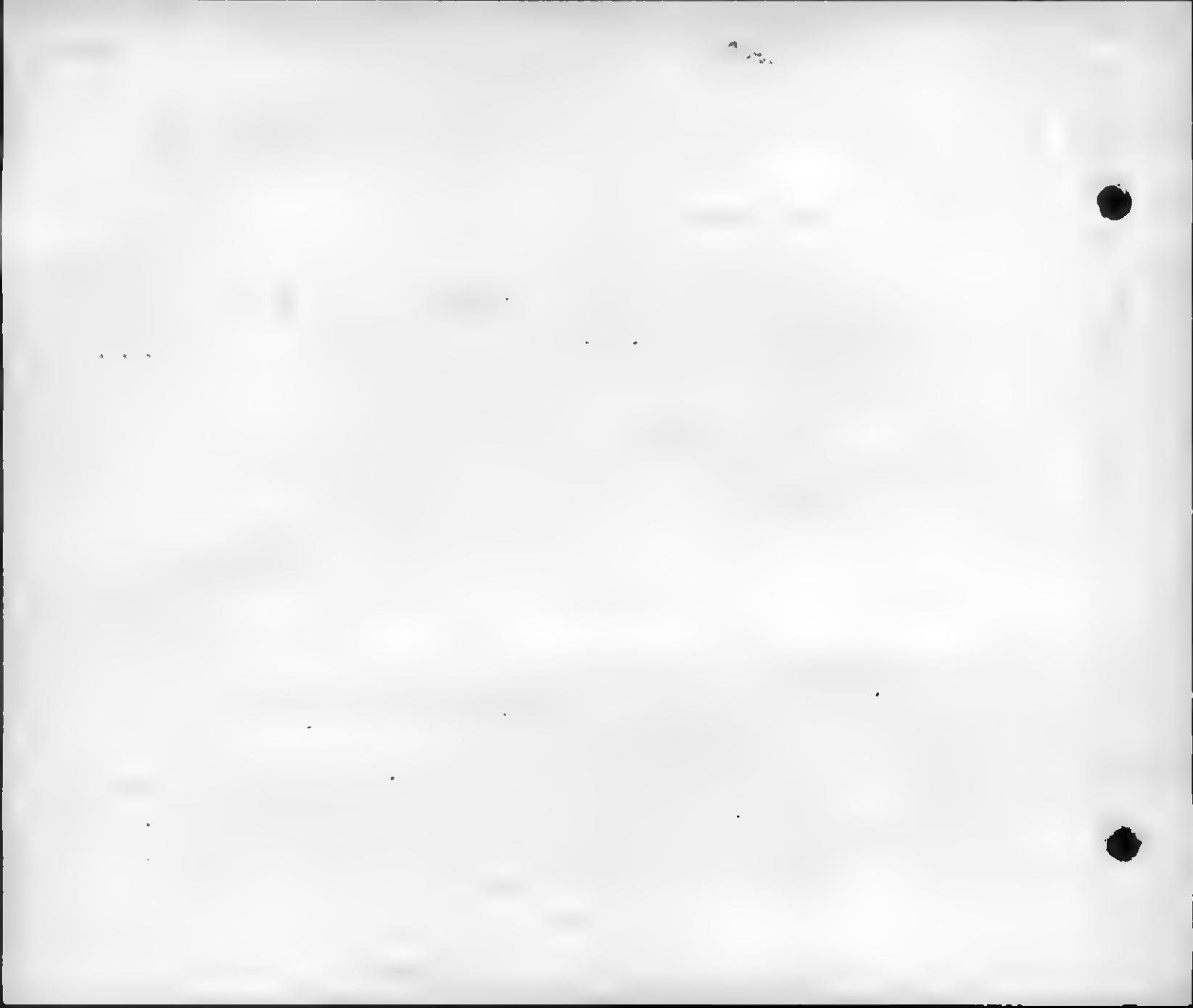
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2696

CERTIFICATE OF DEATH

Reg. Dist. No. 02685

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1 mo 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville		d. STREET ADDRESS Route 1 - Box 26				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) James		First	Middle	Lost	4. DATE OF DEATH 3/12	Month	Day	Year 19 59		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1884	9. AGE (In years lost 1st day) 74 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.				
13. FATHER'S NAME John Ward		14. MOTHER'S MAIDEN NAME Missouri								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 220-09-3102		17. INFORMANT Hospital Records		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO 02 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost (b) DUE TO (c) Aortic Insufficiency Syphilitic Cardiovascular Disease										INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----								
20c. TIME OF INJURY Month, Day, Year Hour o. m. -000- 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County)	(State)	
21. I certify that I attended the deceased from alive on 3/12 , 19 59 , and that death occurred at 6:35 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.								DATE SIGNED 3/13/59
ACTUAL SIGNATURE <i>Leander M.</i>		M.D.								
PHYSICIAN'S NAME (Type) L. BENEDICT M.D.		Crownsville State Hospital, Md.								3/13/59
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/15/59		22c. NAME OF CEMETERY OR CREMATORIUM John Wesley		22d. LOCATION (City, town, or county) Waterbury, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Geese Jr. - Anna, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR MAR 16 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2697

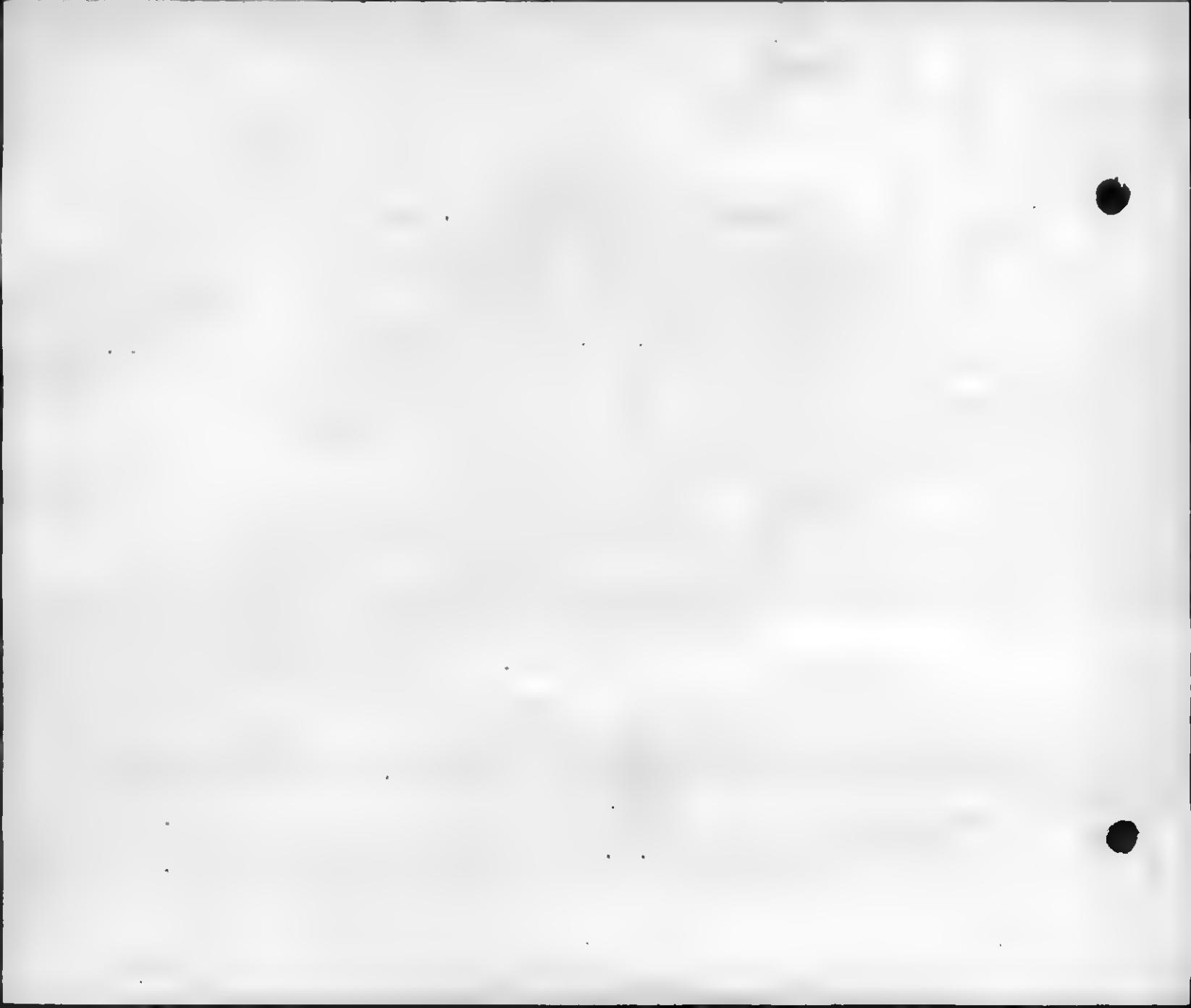
CERTIFICATE OF DEATH

Reg. Dist. No. 02686

1. PLACE OF DEATH o COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE Maryland		COUNTY Baltimore City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 8mo 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 614 N. Fremont Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) John Nathaniel Waters		First John	Middle Nathaniel	Last Waters	4. DATE DEATH 3 4 19 59	Month 3	Day 4	Year 19 59
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/6/92	9. AGE (In years lost birthday) 66 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Receiving Freight		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME John Waters		14. MOTHER'S MAIDEN NAME Georgianna		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes no or unknown] No		16. SOCIAL SECURITY NO. 218-10-9883		17. INFORMANT Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 540.0 (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Doy, Year Hour 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from alive on 3/4 19 59 and that death occurred at 9:45 P.M. from the causes and on the date stated above ACTUAL SIGNATURE <i>Lionel McHenry Mapp, M.D.</i>		6/23 1958 to 3/4 1959		ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.		DATE SIGNED 3/5/59		
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D.		Crownsville State Hospital, Md.				3/5/59		
22a. BURIAL, CREMATION, OR FUNERAL DIRECTOR'S SIGNATURE REMOVAL (Specify) 3/7/59		22b. DATE THEREOF 3/7/59		22c. NAME OF CEMETERY OR CREMATORIAL 16th Avenue		22d. LOCATION (City, town, or county) 15a Cleveland		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles L. Mapp 6616 15a 225 SX</i>		ADDRESS 6616 15a 225 SX		24a. REC'D BY REGISTRAR MAR 12 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>		

1
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 14 hours after death. Page 3 should be filed with the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

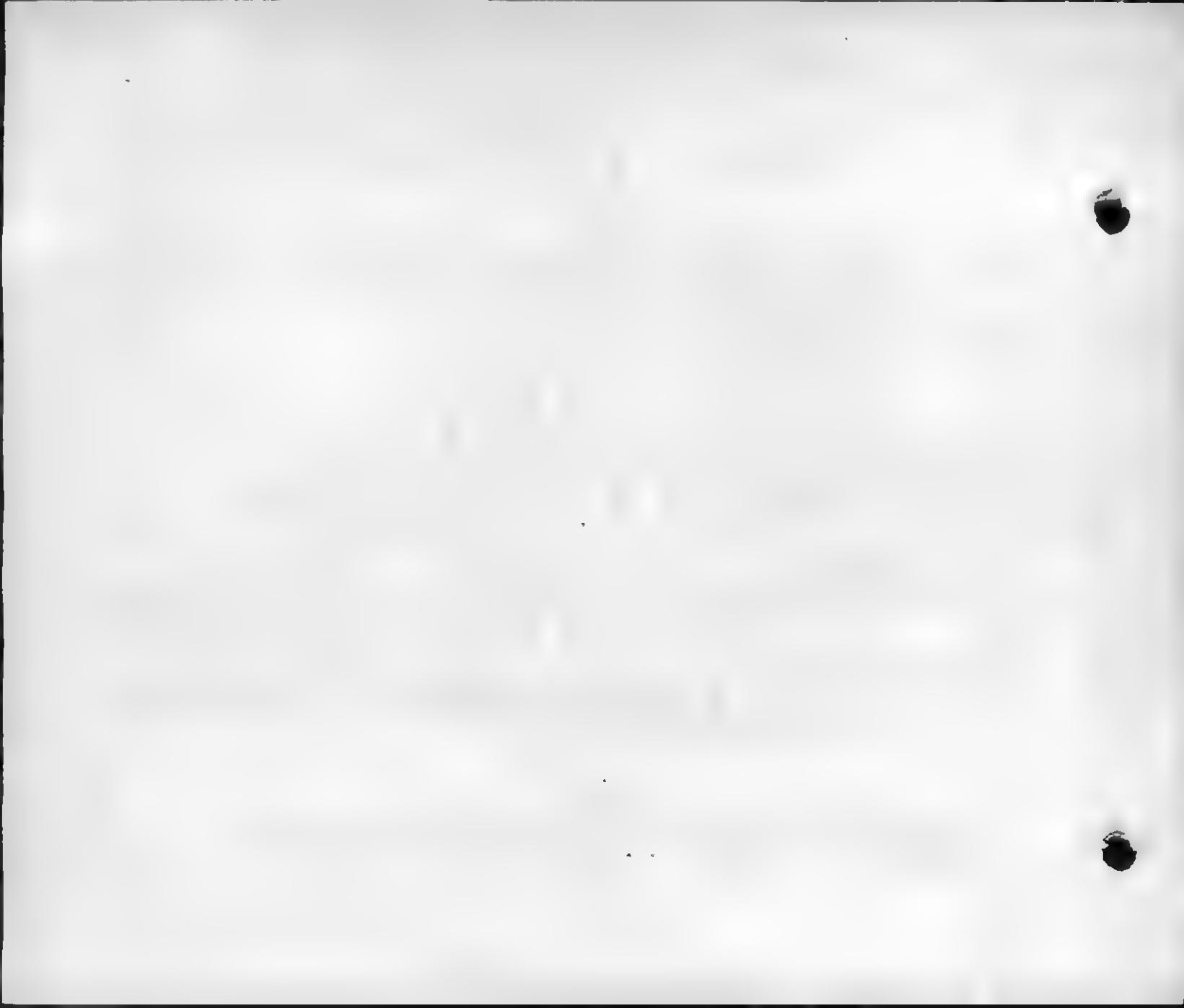
M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2635 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

112557

1. PLACE OF DEATH a. COUNTY Anne Arundel	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS								
3. NAME OF DECEASED (Type or print) Mai	First	Middle	Last	4. DATE OF DEATH WELLS	Month	Day	Year			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED	9. DATE OF BIRTH 9/5/05	10. AGE (in years last birthday) 53 yrs	11. IF UNDER 1 YEAR Months	12. IF UNDER 24 HRS Days	13. IF UNDER 24 HRS Hours	14. IF UNDER 24 HRS Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) A.A. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John Shesley Brown		14. MOTHER'S MAIDEN NAME Annie Brown		15. WAS DECEASED EVER IN U. S. ARMED FORCES (If yes, give war or dates of service) 1970						
16. SOCIAL SECURITY NO.		17. INFORMANT Robert Wells-Anne. Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Syncpe during anesthesia with pentothal and nitrous oxide. 154X XXXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										DATE SIGNED 3/17/59
ACTUAL SIGNATURE Russell S. Fisher		EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 3-19-59		22c. NAME OF CEMETERY OR CREMATORIUM Brewer Dell		22d. LOCATION (City, town, or county) Annapolis		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr.		ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR MAR 18 '59		24b. REGISTRAR'S SIGNATURE Arthur & Fisher				
VS. AT 5ME 8M 2 '57										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. The please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

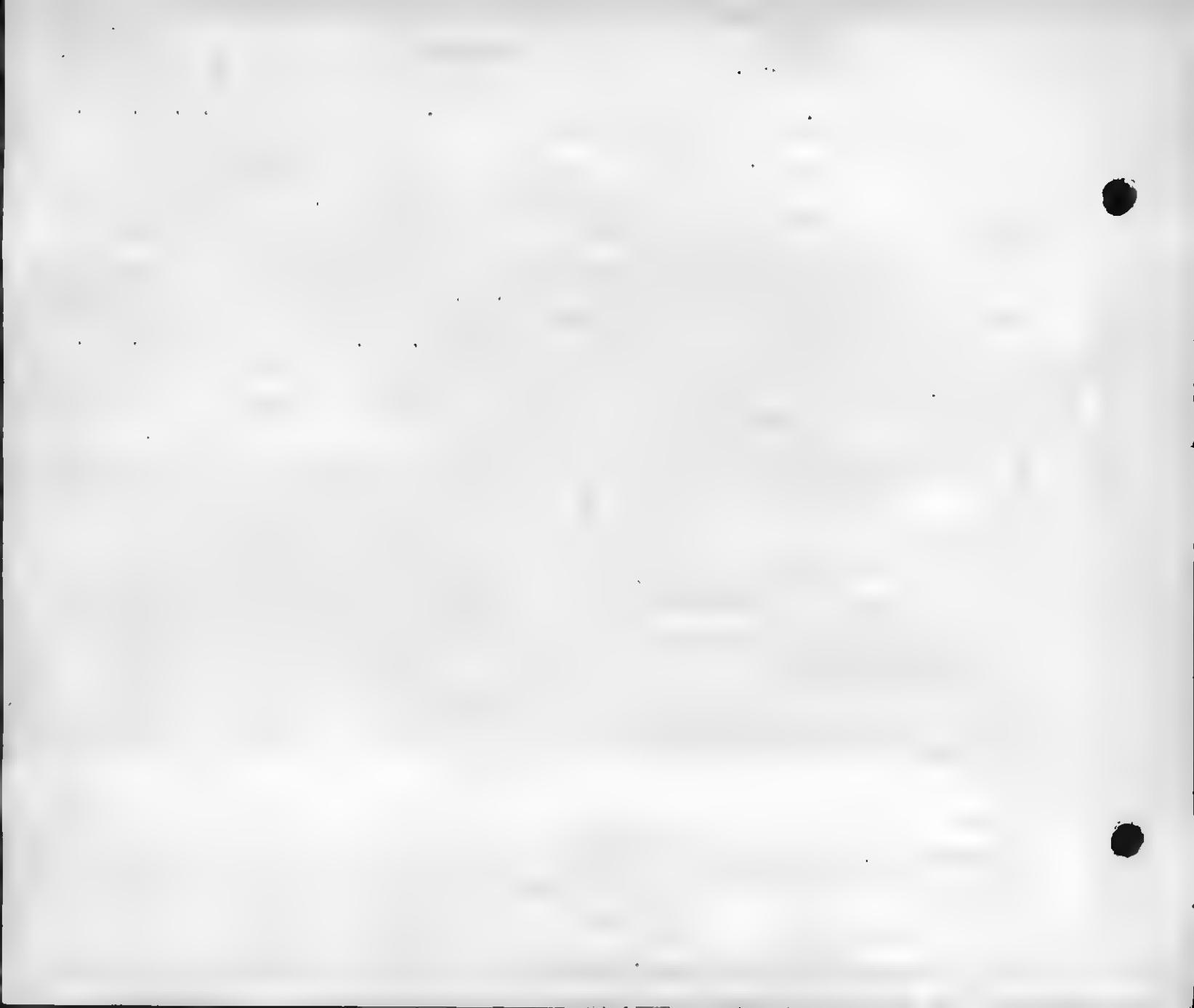
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2698

CERTIFICATE OF DEATH

Reg. Dist. No. 02688

1. PLACE OF DEATH a. COUNTY Anne Ar. County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY A.A.Ct. Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Orchard Beach Md.		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Orchard Beach Pasadena Md.		d. STREET ADDRESS 7912 Seabreeze Dr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rosalie		First	Middle	Last	4. DATE OF DEATH March 26	Month	Year 1959
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 2, 1884		9. AGE (In years last birthday) 74 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. Hubbard		14. MOTHER'S MAIDEN NAME Rose Fitzpatrick					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Police Sert 7912 Seabreeze Dr.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-6-7X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		Pulmonary Edema		INTERVAL BETWEEN ONSET AND DEATH 2 days	
		DUE TO (c)		General Circulation -Arterial Hypertension		6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from Mar. 26 , 1959, to Mar. 26 , 1959, that I last saw the deceased alive on Mar. 26 , 1959, and that death occurred at 1:30 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 1279 William St.			
ACTUAL SIGNATURE C. B. WELTLE	DATE SIGNED 3/28/59						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/59	22c. NAME OF CEMETERY OR CREMATORIAL Baltimore		22d. LOCATION (City, town, or county) 1101 of North Ave.		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE KLINE FUNERAL HOME 1216 S. Charles St.		ADDRESS J. Kline		24a. REC'D BY REGISTRAR MAR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2699

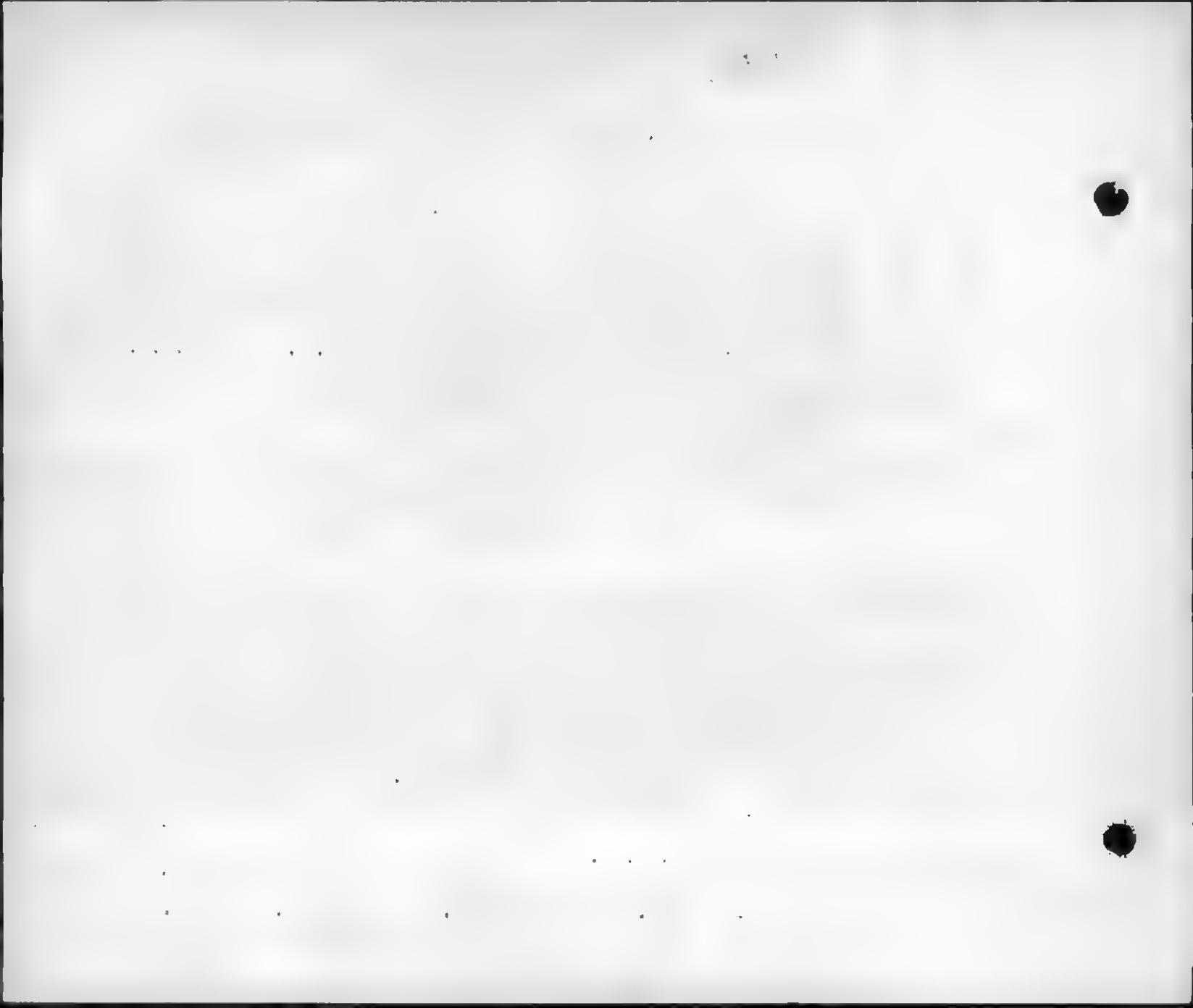
CERTIFICATE OF DEATH

Reg. Dist. No. 82689

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 1mo 5days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 407 N. Payson Street							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Louvenia		Middle Williams		4. DATE OF DEATH 3 10 19 59		Month Day Year							
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1895		9. AGE (In years last birthday) 63		10. IF UNDER 1 YEAR Months 0 Dots 0		11. IF UNDER 24 HRS Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Washington N.C.		12. CITIZEN OF WHAT COUNTRY U.S.A.							
13. FATHER'S NAME Richard Herring		14. MOTHER'S MAIDEN NAME Rosie											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Hospital Records		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation						INTERVAL BETWEEN ONSET AND DEATH							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)													
DUE TO (c)		Aortic Insufficiency											
DUE TO (c)		Syphilis											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Uremia and Anemia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----											
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- p. m. ----- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2/5 , 19 59 , to 3/10 , 19 59 , that I last saw the deceased alive on 3/10 , 19 59 , and that death occurred at 5:00A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.						DATE SIGNED 3/10/59							
ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i>													
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 14, 59		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Auburn Cem.		22d. LOCATION (City, town, or county) Balto. Md.							
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mrs. Kate R. Williams Schroeder</i>		ADDRESS 322 N. Mar 16 '59		24a. REC'D BY REGISTRAR Arthur S. Trahan		24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2700

CERTIFICATE OF DEATH

Reg. Dist. No.

02691

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE	
Anne Arundel MARYLAND		MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Pasodena Md 9 yrs x sole walesford		AA	
c. LENGTH OF STAY IN b.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
Sole walesford		Pasodena Md	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Raymond Napoleon Windsor		Raymond	Napoleon
Last		Windsor	March 9
4. DATE OF DEATH		Month	Day
		March	19
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
M		W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months Days
March 29 1890		68 yrs	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Coxwain		Navy	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Churchtown Md U.S.		U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Windsor		Howe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO	
No		17. INFORMANT	
17. INFORMANT		Address	
John Windsor wife Henrietta Windsor			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Hemorrhage	
443x			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			
(b)		Hypertensive C.V. Disease	
DUE TO			
(c)		Per-arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955, 19, to 1959, 19, that I last saw the deceased alive on 3-7-59, 19, and that death occurred at 11 A.M. from the causes and on the date stated above		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		DATE SIGNED	
PHYSICIAN'S NAME (Type)		Robert R. Helms	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		March 12, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)	
Lawson Park		Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
J. V. Dugger		Glen Burnie, Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
VS ATS (4)		DATE MAR 12 '59	
15M 10/57		Arthur S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 that may be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2636

CERTIFICATE OF DEATH

Reg. Dist. No.

02691

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>1 week</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Odenton</i>	
d. STREET ADDRESS <i>1st St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Charlie</i>	Middle <i>E.</i>	Last 4. DATE OF DEATH <i>YOUNG</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>23 Dec 58</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>infant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
10c. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		9. AGE (In years last birthday) yrs. <i>2 10</i>	
11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		12. IF UNDER 1 YEAR Months <i>2</i> Days <i>10</i> Hours <i>0</i> Min. <i>0</i>	
13. FATHER'S NAME <i>Edward Young</i>		14. MOTHER'S MAIDEN NAME <i>ERVAHEE V. COLE</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mother - SAME AS #2</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i>	
754.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) (c)		DUE TO <i>Congenital Intra ventricular septal defect + pulmonary hypertension since birth</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bilateral bronchopneumonia - congenital 'horseshoe' renal defect</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>RIVER CLUB ESTATES</i> (County) <i>EDGEMARSH</i> (State) <i>M.D.</i>	
21. I certify that I attended the deceased from <i>23 Feb 1959</i> to <i>2 MAR 1959</i> that I last saw the deceased alive on <i>2 MAR 1959</i> , and that death occurred at <i>9:15 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James I. Hudson, Jr.</i>		ADDRESS (Street, city or town, state) <i>RIVER CLUB ESTATES</i>	
PHYSICIAN'S NAME (Type) <i>JAMES I. HUDSON, JR.</i>		DATE SIGNED <i>3 MAR 59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>March 5, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Hillcrest Memorial Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping Funeral Home</i>		ADDRESS <i>Annapolis, Md.</i>	
24a. REC'D BY REGISTRAR <i>MAR 9 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hopping</i>	

CERTIFICATE OF DEATH

Date of Birth:

Cause of Death:

Place of Death:

Name of Hospital:

Name of Doctor:

Name of Mortician:

Name of Cemetery:

Name of Funeral Home:

Name of Embalmer:

Name of Coffin:

Name of Linen:

Name of Casket:

Name of Coffin Liner:

Name of Casket Liner:

Name of Casket Liner Liner:

Name of Casket Liner Liner Liner:

Name of Casket Liner Liner Liner Liner:

Name of Casket Liner Liner Liner Liner Liner:

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Name of Casket Liner Liner Liner Liner Liner Liner Liner Liner Liner Liner:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02692

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Same		b. COUNTY Same		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn		c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same		d. STREET ADDRESS Same		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Quaterfield Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Denise Dianne Young		First	Middle	Lost	4. DATE OF DEATH March 26th.	Month	Doy	Year 19 59
5. SEX F.		6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/25/59	9. AGE (in years less birthday yrs.)	10. IF UNDER 1 YEAR 2	11. IF UNDER 24 HRS. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Bowling Green, Kentucky.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Young		14. MOTHER'S MAIDEN NAME Ruth Taylor		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Sergeant and Mrs. Wm. Young (parents)		
17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
DUE TO 9240		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO (c)		INTERVAL BETWEEN DEATH AND AUTOPSY Sudden		
20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Baby's face was in direct contact with the pillow.		20c. TIME OF INJURY Month, Day, Year Hour a. m. Unknown 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Crib (Home)		
20f. (City or town) Severn, Md.		20g. (County) A.A.		20h. (State) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. ACTUAL SIGNATURE Gustave H. Faubert, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/26/59		
23. EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		24. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 27, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery		22d. LOCATION (City, town, or county) Bowling Green, Kentucky.		
23. FUNERAL DIRECTOR'S SIGNATURE Richard T. Leighton		24. ADDRESS Glen Burnie, Maryland		24c. REC'D BY REGISTRAR DATE MAR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knott		

STATE OF TEXAS
DEPARTMENT OF PUBLIC SAFETY
FIRE AND STORM EMERGENCY MANAGEMENT

2010

STATE
2010

NAME	ADDRESS	PHONE	EMAIL	NOTES
John Doe	123 Main Street	555-1234	john.doe@state.tx.us	Primary contact
Jane Doe	456 Elm Street	555-2345	jane.doe@state.tx.us	Secondary contact
Bob Smith	789 Oak Street	555-3456	bob.smith@state.tx.us	Emergency contact
Charlie Brown	101 Pine Street	555-4567	charlie.brown@state.tx.us	Administrative contact
David Lee	202 Cedar Street	555-5678	david.lee@state.tx.us	Training contact
Emily Parker	303 Elm Street	555-6789	emily.parker@state.tx.us	Public Relations contact
Frank Wilson	404 Pine Street	555-7890	frank.wilson@state.tx.us	Logistics contact
Grace Lee	505 Cedar Street	555-8901	grace.lee@state.tx.us	Financial contact
Henry Parker	606 Elm Street	555-9012	henry.parker@state.tx.us	Community Relations contact
Isabel Wilson	707 Pine Street	555-0123	isabel.wilson@state.tx.us	Media Relations contact
James Lee	808 Cedar Street	555-1234	james.lee@state.tx.us	Training contact
Karen Parker	909 Elm Street	555-2345	karen.parker@state.tx.us	Public Relations contact
Louis Wilson	1010 Pine Street	555-3456	louis.wilson@state.tx.us	Logistics contact
Mary Lee	1111 Cedar Street	555-4567	mary.lee@state.tx.us	Financial contact
Nancy Parker	1212 Elm Street	555-5678	nancy.parker@state.tx.us	Community Relations contact
Oliver Wilson	1313 Pine Street	555-6789	oliver.wilson@state.tx.us	Media Relations contact
Peter Lee	1414 Cedar Street	555-7890	peter.lee@state.tx.us	Training contact
Quincy Parker	1515 Elm Street	555-8901	quincy.parker@state.tx.us	Public Relations contact
Ronald Wilson	1616 Pine Street	555-9012	ronald.wilson@state.tx.us	Logistics contact
Sophia Lee	1717 Cedar Street	555-0123	sophia.lee@state.tx.us	Financial contact
Ulysses Parker	1818 Elm Street	555-1234	ulysses.parker@state.tx.us	Community Relations contact
Victoria Wilson	1919 Pine Street	555-2345	victoria.wilson@state.tx.us	Media Relations contact
Walter Lee	2020 Cedar Street	555-3456	walter.lee@state.tx.us	Training contact
Xavier Parker	2121 Elm Street	555-4567	xavier.parker@state.tx.us	Public Relations contact
Yolanda Wilson	2222 Pine Street	555-5678	yolanda.wilson@state.tx.us	Logistics contact
Zachary Lee	2323 Cedar Street	555-6789	zachary.lee@state.tx.us	Financial contact
Abigail Parker	2424 Elm Street	555-7890	abigail.parker@state.tx.us	Community Relations contact
Calvin Wilson	2525 Pine Street	555-8901	calvin.wilson@state.tx.us	Media Relations contact
Doris Lee	2626 Cedar Street	555-9012	doris.lee@state.tx.us	Training contact
Ernest Parker	2727 Elm Street	555-0123	ernest.parker@state.tx.us	Public Relations contact
Felicity Wilson	2828 Pine Street	555-1234	felicity.wilson@state.tx.us	Logistics contact
Grace Lee	2929 Cedar Street	555-2345	grace.lee@state.tx.us	Financial contact
Henry Parker	3030 Elm Street	555-3456	henry.parker@state.tx.us	Community Relations contact
Isabel Wilson	3131 Pine Street	555-4567	isabel.wilson@state.tx.us	Media Relations contact
James Lee	3232 Cedar Street	555-5678	james.lee@state.tx.us	Training contact
Karen Parker	3333 Elm Street	555-6789	karen.parker@state.tx.us	Public Relations contact
Louis Wilson	3434 Pine Street	555-7890	louis.wilson@state.tx.us	Logistics contact
Mary Lee	3535 Cedar Street	555-8901	mary.lee@state.tx.us	Financial contact
Nancy Parker	3636 Elm Street	555-9012	nancy.parker@state.tx.us	Community Relations contact
Oliver Wilson	3737 Pine Street	555-0123	oliver.wilson@state.tx.us	Media Relations contact
Peter Lee	3838 Cedar Street	555-1234	peter.lee@state.tx.us	Training contact
Quincy Parker	3939 Elm Street	555-2345	quincy.parker@state.tx.us	Public Relations contact
Ronald Wilson	4040 Pine Street	555-3456	ronald.wilson@state.tx.us	Logistics contact
Sophia Lee	4141 Cedar Street	555-4567	sophia.lee@state.tx.us	Financial contact
Ulysses Parker	4242 Elm Street	555-5678	ulysses.parker@state.tx.us	Community Relations contact
Victoria Wilson	4343 Pine Street	555-6789	victoria.wilson@state.tx.us	Media Relations contact
Walter Lee	4444 Cedar Street	555-7890	walter.lee@state.tx.us	Training contact
Xavier Parker	4545 Elm Street	555-8901	xavier.parker@state.tx.us	Public Relations contact
Yolanda Wilson	4646 Pine Street	555-9012	yolanda.wilson@state.tx.us	Logistics contact
Zachary Lee	4747 Cedar Street	555-0123	zachary.lee@state.tx.us	Financial contact
Abigail Parker	4848 Elm Street	555-1234	abigail.parker@state.tx.us	Community Relations contact
Calvin Wilson	4949 Pine Street	555-2345	calvin.wilson@state.tx.us	Media Relations contact
Doris Lee	5050 Cedar Street	555-3456	doris.lee@state.tx.us	Training contact
Ernest Parker	5151 Elm Street	555-4567	ernest.parker@state.tx.us	Public Relations contact
Felicity Wilson	5252 Pine Street	555-5678	felicity.wilson@state.tx.us	Logistics contact
Grace Lee	5353 Cedar Street	555-6789	grace.lee@state.tx.us	Financial contact
Henry Parker	5454 Elm Street	555-7890	henry.parker@state.tx.us	Community Relations contact
Isabel Wilson	5555 Pine Street	555-8901	isabel.wilson@state.tx.us	Media Relations contact
James Lee	5656 Cedar Street	555-9012	james.lee@state.tx.us	Training contact
Karen Parker	5757 Elm Street	555-0123	karen.parker@state.tx.us	Public Relations contact
Louis Wilson	5858 Pine Street	555-1234	louis.wilson@state.tx.us	Logistics contact
Mary Lee	5959 Cedar Street	555-2345	mary.lee@state.tx.us	Financial contact
Nancy Parker	6060 Elm Street	555-3456	nancy.parker@state.tx.us	Community Relations contact
Oliver Wilson	6161 Pine Street	555-4567	oliver.wilson@state.tx.us	Media Relations contact
Peter Lee	6262 Cedar Street	555-5678	peter.lee@state.tx.us	Training contact
Quincy Parker	6363 Elm Street	555-6789	quincy.parker@state.tx.us	Public Relations contact
Ronald Wilson	6464 Pine Street	555-7890	ronald.wilson@state.tx.us	Logistics contact
Sophia Lee	6565 Cedar Street	555-8901	sophia.lee@state.tx.us	Financial contact
Ulysses Parker	6666 Elm Street	555-9012	ulysses.parker@state.tx.us	Community Relations contact
Victoria Wilson	6767 Pine Street	555-0123	victoria.wilson@state.tx.us	Media Relations contact
Walter Lee	6868 Cedar Street	555-1234	walter.lee@state.tx.us	Training contact
Xavier Parker	6969 Elm Street	555-2345	xavier.parker@state.tx.us	Public Relations contact
Yolanda Wilson	7070 Pine Street	555-3456	yolanda.wilson@state.tx.us	Logistics contact
Zachary Lee	7171 Cedar Street	555-4567	zachary.lee@state.tx.us	Financial contact
Abigail Parker	7272 Elm Street	555-5678	abigail.parker@state.tx.us	Community Relations contact
Calvin Wilson	7373 Pine Street	555-6789	calvin.wilson@state.tx.us	Media Relations contact
Doris Lee	7474 Cedar Street	555-7890	doris.lee@state.tx.us	Training contact
Ernest Parker	7575 Elm Street	555-8901	ernest.parker@state.tx.us	Public Relations contact
Felicity Wilson	7676 Pine Street	555-9012	felicity.wilson@state.tx.us	Logistics contact
Grace Lee	7777 Cedar Street	555-0123	grace.lee@state.tx.us	Financial contact
Henry Parker	7878 Elm Street	555-1234	henry.parker@state.tx.us	Community Relations contact
Isabel Wilson	7979 Pine Street	555-2345	isabel.wilson@state.tx.us	Media Relations contact
James Lee	8080 Cedar Street	555-3456	james.lee@state.tx.us	Training contact
Karen Parker	8181 Elm Street	555-4567	karen.parker@state.tx.us	Public Relations contact
Louis Wilson	8282 Pine Street	555-5678	louis.wilson@state.tx.us	Logistics contact
Mary Lee	8383 Cedar Street	555-6789	mary.lee@state.tx.us	Financial contact
Nancy Parker	8484 Elm Street	555-7890	nancy.parker@state.tx.us	Community Relations contact
Oliver Wilson	8585 Pine Street	555-8901	oliver.wilson@state.tx.us	Media Relations contact
Peter Lee	8686 Cedar Street	555-9012	peter.lee@state.tx.us	Training contact
Quincy Parker	8787 Elm Street	555-0123	quincy.parker@state.tx.us	Public Relations contact
Ronald Wilson	8888 Pine Street	555-1234	ronald.wilson@state.tx.us	Logistics contact
Sophia Lee	8989 Cedar Street	555-2345	sophia.lee@state.tx.us	Financial contact
Ulysses Parker	9090 Elm Street	555-3456	ulysses.parker@state.tx.us	Community Relations contact
Victoria Wilson	9191 Pine Street	555-4567	victoria.wilson@state.tx.us	Media Relations contact
Walter Lee	9292 Cedar Street	555-5678	walter.lee@state.tx.us	Training contact
Xavier Parker	9393 Elm Street	555-6789	xavier.parker@state.tx.us	Public Relations contact
Yolanda Wilson	9494 Pine Street	555-7890	yolanda.wilson@state.tx.us	Logistics contact
Zachary Lee	9595 Cedar Street	555-8901	zachary.lee@state.tx.us	Financial contact
Abigail Parker	9696 Elm Street	555-9012	abigail.parker@state.tx.us	Community Relations contact
Calvin Wilson	9797 Pine Street	555-0123	calvin.wilson@state.tx.us	Media Relations contact
Doris Lee	9898 Cedar Street	555-1234	doris.lee@state.tx.us	Training contact
Ernest Parker	9999 Elm Street	555-2345	ernest.parker@state.tx.us	Public Relations contact
Felicity Wilson	10101 Pine Street	555-3456	felicity.wilson@state.tx.us	Logistics contact
Grace Lee	10202 Cedar Street	555-4567	grace.lee@state.tx.us	Financial contact
Henry Parker	10303 Elm Street	555-5678	henry.parker@state.tx.us	Community Relations contact
Isabel Wilson	10404 Pine Street	555-6789	isabel.wilson@state.tx.us	Media Relations contact
James Lee	10505 Cedar Street	555-7890	james.lee@state.tx.us	Training contact
Karen Parker	10606 Elm Street	555-8901	karen.parker@state.tx.us	Public Relations contact
Louis Wilson	10707 Pine Street	555-9012	louis.wilson@state.tx.us	Logistics contact
Mary Lee	10808 Cedar Street	555-0123	mary.lee@state.tx.us	Financial contact
Nancy Parker	10909 Elm Street	555-1234	nancy.parker@state.tx.us	Community Relations contact
Oliver Wilson	11010 Pine Street	555-2345	oliver.wilson@state.tx.us	Media Relations contact
Peter Lee	11111 Cedar Street	555-3456	peter.lee@state.tx.us	Training contact
Quincy Parker	11212 Elm Street	555-4567	quincy.parker@state.tx.us	Public Relations contact
Ronald Wilson	11313 Pine Street	555-5678	ronald.wilson@state.tx.us	Logistics contact
Sophia Lee	11414 Cedar Street	555-6789	sophia.lee@state.tx.us	Financial contact
Ulysses Parker	11515 Elm Street	555-7890	ulysses.parker@state.tx.us	Community Relations contact
Victoria Wilson	11616 Pine Street	555-8901	victoria.wilson@state.tx.us	Media Relations contact
Walter Lee	11717 Cedar Street	555-9012	walter.lee@state.tx.us	Training contact
Xavier Parker	11818 Elm Street	555-0123	xavier.parker@state.tx.us	Public Relations contact
Yolanda Wilson	11919 Pine Street	555-1234	yolanda.wilson@state.tx.us	Logistics contact
Zachary Lee	12020 Cedar Street	555-2345	zachary.lee@state.tx.us	Financial contact
Abigail Parker	12121 Elm Street	555-3456	abigail.parker@state.tx.us	Community Relations contact
Calvin Wilson	12222 Pine Street	555-4567	calvin.wilson@state.tx.us	Media Relations contact
Doris Lee	12323 Cedar Street	555-5678	doris.lee@state.tx.us	Training contact
Ernest Parker	12424 Elm Street	555-6789	ernest.parker@state.tx.us	Public Relations contact
Felicity Wilson	12525 Pine Street	555-7890	felicity.wilson@state.tx.us	Logistics contact
Grace Lee	12626 Cedar Street	555-8901	grace.lee@state.tx.us	Financial contact
Henry Parker	12727 Elm Street	555-9012	henry.parker@state.tx.us	Community Relations contact
Isabel Wilson	12828 Pine Street	555-0123	isabel.wilson@state.tx.us	Media Relations contact
James Lee	12929 Cedar Street	555-1234	james.lee@state.tx.us	Training contact
Karen Parker	13030 Elm Street	555-2345	karen.parker@state.tx.us	Public Relations contact
Louis Wilson	13131 Pine Street	555-3456	louis.wilson@state.tx.us	Logistics contact
Mary Lee	13232 Cedar Street	555-4567	mary.lee@state.tx.us	Financial contact
Nancy Parker	13333 Elm Street	555-5678	nancy.parker@state.tx.us	Community Relations contact
Oliver Wilson	13434 Pine Street	555-6789	oliver.wilson@state.tx.us	Media Relations contact
Peter Lee	13535 Cedar Street	555-7890	peter.lee@state.tx.us	Training contact
Quincy Parker	13636 Elm Street	555-8901	quincy.parker@state.tx.us	Public Relations contact
Ronald Wilson	13737 Pine Street	555-9012	ronald.wilson@state.tx.us	Logistics contact
Sophia Lee	13838 Cedar Street	555-0123	sophia.lee@state.tx.us	Financial contact
Ulysses Parker	13939 Elm Street	555-1234	ulysses.parker@state.tx.us	Community Relations contact
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